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Chicago.

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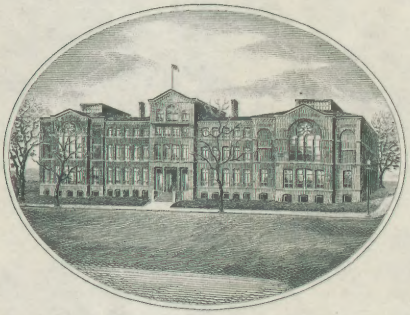

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PERSONALITY DEVELOPMENT AND ITS IMPLICATIONS FOR NURSING AND NURSING EDUCATION

PROCEEDINGS OF AN INSTITUTE ON NURSING EDUCATION

STATE OF ILLINOIS
DEPARTMENT OF PUBLIC HEALTH
SPRINGFIELD, ILLINOIS

PERSONALITY DEVELOPMENT AND ITS IMPLICATIONS FOR NURSING AND NURSING EDUCATION

PROCEEDINGS OF AN INSTITUTE ON NURSING EDUCATION, Chicago, 1948

HELD

NOVEMBER 4, 5, AND 6, 1948

AT THE

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University of Illinois

CHICAGO

SPONSORED BY

THE ILLINOIS SOCIETY FOR MENTAL HYGIENE

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SPRINGFIELD, ILLINOIS

1949

FOREWORD

The Institute, of which the following are the proceedings, grew out of a conviction on the part of the Education Committee of the Illinois Society for Mental Hygiene that education for mental health is the responsibility of all professional people.

In line with this conviction, it was decided to offer an institute to the faculties of the general nursing schools in the State on the theory that the student nurse was reached most effectively through the faculty.

The Institute was planned not so much to give a body of information to the faculty members for conveyance to their students as to help them to understand their students and nurse-patient relationships through a discussion of personality development.

The general plan of the Institute called for general sessions in the morning with the student body broken up into small discussion groups in the afternoon. These discussion groups all devoted their time to a discussion of the morning sessions rather than to separate topics. The purpose of the groups was to give the students a chance under expert leadership to think through the ideas they had gathered in the morning in terms of their jobs and relationships.

Out of a total of ninety nursing schools in Illinois, fifty-four were invited to participate in the Chicago Institute. A second institute was planned for the downstate area. Out of the fifty-four schools invited, thirty-four participated, with seventy representatives attending. Twelve of these schools were from outside Chicago, with a total of twenty-four persons attending. Twenty-three were Chicago schools, with a total of forty-six persons attending. There were eight non-school agencies represented by twelve delegates.

A breakdown of the faculty positions held by the students might be of interest. The following list is not complete, due to omissions on the application forms:

7	Director of Nurses	2	Hospital Nursing Consultants
8	Asst. Director of Nurses	3	Pediatric Nursing Instructors
9	Education Directors	1	Psychiatric Nursing Instructor
16	Clinical Instructors	1	Student's Records and Asst. Librarian
2	Medicine and Surgery Instructors		
9	Nursing Arts Instructors		
33	Student Counselors		
2	Supervisors		

An effort was made to assess the reaction of the students to the Institute by having them write comments, criticisms, and suggestions anonymously on the last day of the Institute.

The Illinois Society for Mental Hygiene expresses its appreciation to the co-operating agencies for their help in making this program possible. The members of the Planning Committee are hereby praised for their sustaining interest and enthusiasm. Without their encouragement and help this Institute could not have been successful.

Special mention should be made of the fact that the Institute was financed with National Mental Health Act funds, made available by the Illinois Department of Public Health.

Louis de Boer
June 8, 1949.

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Staff, Institute for Psychoanalysis of Chicago.

DR. FRED ROBBINS
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HELEN RUCH, R.N., Veterans Rehabilitation Center.

MAVIS URBANCEK, R.N., Illinois Neuropsychiatric Institute.

MARION KALKMAN, R.N., Illinois Neuropsychiatric Institute.

MARY McLEAN, R.N., Illinois Neuropsychiatric Institute.

PAULA F. WEINS, R.N., North Shore Health Resort.

ROSE BIGLER, R.N., Chicago State Hospital Nursing School.

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MARION KALKMAN, R.N., Illinois Neuropsychiatric Institute.

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PAULA WEINS, R.N., North Shore Health Resort.

LOUIS de BOER, Committee Secretary and General Institute Chairman, Education Secretary, Illinois Society for Mental Hygiene.

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THURSDAY MORNING SESSION

November 4, 1948

The first General Session of the Institute on Nursing Education sponsored by the Illinois Society for Mental Hygiene in cooperation with the Illinois Department of Registration and Education and the Illinois Department of Public Health convened on the third floor of the Student Illini Building, University of Illinois, 715 South Wood Street, Chicago, Illinois, at nine forty-five o'clock, with Mr. Louis de Boer, presiding.

CHAIRMAN LOUIS DE BOER: I am most pleased to call this opening meeting of the Institute on Nursing Education to attention. This Institute is being sponsored by the Illinois Society for Mental Hygiene in cooperation with the Illinois Department of Registration and Education and the Illinois Department of Public Health. In the name of these two Departments of the State of Illinois and the Society, I welcome you, the delegates of some fifty-four nursing schools in the Northern Illinois area.

We feel honored to be able to be of service to you by offering this program on mental hygiene.

You know this program was planned and conceived by your friends. Mrs. Bernoudy and Miss Balaty of the Department of Registration and Education were most helpful and gave not only of their time and interest, but really pushed the idea and were most enthusiastic.

Dr. Gustave Weinfeld was the chairman of the Planning Committee. I mention him now because you see, Mrs. Bernoudy and Miss Balaty were in the planning activity even before a committee got started. Dr. Weinfeld and Miss Marion Kalkman were the official committee of the Society. They invited the advisors

who are listed on the back of your program, Mary Brophy, Florence Blake, Gladys Kiniery, Dr. Fred Robbins, Sister Mary Therese, and Paula Weins, to assist in the planning. They planned this program and its value and its quality are a product of their thinking.

Before leaving the announcements I cannot but call your attention to the generosity of the Illinois Department of Public Health, through its Director, Dr. Roland R. Cross, who gave the funds which will make this Institute possible. These funds are granted under the National Mental Health Act.

Opening our session this morning we have none other than Dr. Francis J. Gerty who is so well known to many of you and beloved by all of us. Dr. Gerty as you know is head of the Department of Psychiatry at the University of Illinois, and I am sure needs no further introduction. He will give us the keynote address of this Institute. Dr. Francis Gerty.

THE NURSE AND MENTAL HYGIENE

FRANCIS J. GERTY, M.D.

Delegates, Mr. de Boer's introduction and the program title of "Keynote Address" might suggest that I am to make a political speech. From my beginning you may think I am making a political speech.

For the thirty hours since we have known the results of the last Presidential election, experts have been running to cover. Newspapers have been trying to explain something that has happened that wasn't expected. How did this thing happen? Does it yield us any lesson which can be useful to nurses? I think that it does. All events in human society teach us something of the lesson that we need to learn if we are to train people who are to be engaged in one aspect or another of the treatment of patients.

Now, consider the experts in this recent election forecast. Are they ignorant and unintelligent men? Not at all. Were the techniques that they used without merit? No. Were they improperly motivated? Is there something out of self-interest which decided their prognostications? Decidedly not.

These people live by being correct in their prognostications, but they were wrong. How did that happen? That has something to do with our problem.

Here we had a lot of people who were used to judging situations according to certain standards based on tradition, and they were astoundingly—some say disastrously—wrong—their wrongness was conclusive. No one doubts that it must have some explanation.

Now, while all of the other experts are searching around, digging up explanations and junking what they had written before trying to explain their mistakes, I think we might try to do a little experting on our own.

Why was Truman successful? Well, my opinion for what it's worth—and it isn't worth much on some of the aspects of this—is that the man who prevailed was one who had been able to relate himself to people. Now, which people? Not the ones presumably in the "know", —the men in political organizations or the ones expert in making polls of opinion. Obviously those weren't the people that he had related himself to. There seems to be something mysterious and secret about it because the pollsters couldn't find out where these people were.

He probably related himself to people that the pollsters did not relate themselves to,—one who remained concealed from pollsters.

To me this means that strong and forceful,—determining,—springs of action are often deeply concealed in our individual natures as in our voting population. The successful physician, nurse, and person is the one

who can relate himself to people so that he can get at, and make good, intelligent use of these forces. Is it the intelligent thing that we should blind ourselves to facts such as these? Now, let's get into my main subject.

Why do I use this kind of an introduction to the nurse, her training, and her place in the field of mental hygiene? I recall that when I was an intern at the Cook County Hospital they had just done away with the regulation that nurses might not go out socially with interns. In spite of the fact that some of the leading members of the staff had married nurses in spite of this rule, the rule had only recently been removed.

There used to be a good deal of talk about the dignity that should attach to the position of nurse. This dignity was even signified by a symbol. I seem to recall that nurses at times used to refer to their caps as their dignity. Their dignity had to be on at the right and proper occasions.

Nurses still somehow or other managed to behave as human beings in spite of the requirement that they use artificial symbols of dignity. I have often wondered as to the relative value of the various parts of their education, or training, as it used to be called. How much of their education was directed toward understanding how they acted as human beings, especially in relation to other human beings, and how much was directed to the information, to the techniques, which were involved in nursing procedures? Was there a disproportion? We know that with nurses, as with others, the human side often upsets the more technical acquisitions of training. Today they certainly should be possessed of something practical concerning human relationships.

I doubt that they will learn this something practical if only the intellectual preparation and the training in procedures and techniques are stressed during their

schooling and practical work with patients. Many things can be assumed superficially in the same manner that they were supposed to assume the cap as a symbol of dignity.

Now, what is dignity? We recognize it as a desirable quality. Does it mean a bearing that is something like the bearing of proudness, but not quite the same thing? Does it mean having all the outward appurtenances of a place or station? I think it does not. Almost all such outward appearances might be lacking and a person might still be dignified. Dignity has something to do with the intelligent recognition of one's own rights and feelings as a person in comparison to the rights and feelings of other people as persons. Very simple men, poorly dressed, may be dignified. The dignified man strives to deal honorably and kindly with others, trusting that the justice he shows others will justify himself.

I look at dignity as this, an internal matter of character, rather than as a superficial matter of bearing,—a technique to be practiced. It is not always easy to distinguish between a spurious dignity and a real dignity. Sometimes the histrionic ability of a person is such that it is very hard to tell the real from the false.

Unfortunately, this becomes increasingly true as the person is more intelligent and more intelligently aware of the advantages of having the proper appearance.

Dignity in the sense in which I have spoken is an essential characteristic of the good nurse. How do we learn to become aware of our own proper status and position with reference to the position of others with whom we are thrown in relation in our work and in our every-day affairs?

Nursing isn't a unilateral activity in service. It involves the nurse and it involves other people. Every nurse intuitively perceives that in some things she is like

other people and that in other things she is different. Intuitive perception may lead to intuitive action. This may be bad as well as good in its results for intuition is a feeling recognition springing from hidden sources. Feelings of liking and akinness and of disliking and difference may have too much weight in determining action unless we gain some practical understanding of what these feelings of being for, against or indifferent mean. With some patients a nurse may feel that she gets along easily. With others she doesn't get along so easily or may have actual difficulty,—a so-called clash of personalities.

If you could go into a large medical ward such as you will find in the County Hospital or on a busy floor in a private hospital, and you could have the ability to find out just what the nurse in charge of the ward or floor feels about the several patients, you will grasp what I mean. You probably have been in that position yourself. "So and so is easy to get along with. He even helps in the hospital situation. So and so is a grumpy discontented individual. You mustn's let him go too far. If you do, he will take advantage or cause trouble.

"Mrs. so and so in this room is pampered by her husband. She stays in bed unnecessarily. There really isn't anything wrong with her. All the tests are negative. I wonder why Doctor so and so keeps her in the hospital?"

All these matters have something to do with the way the nurse is related to patient and all of them deserve some attention and some study. We can find terms in the dictionary that may even serve to label or define such situations. In fact, I think one of the defects of our teaching is that we depend too much on the terms; meanings tend to become hackneyed and commonplace and still do not signify the same things to the different people

who use them. Yet fundamental and complex feelings have real existence to all people. They are important in all human relationships. We would be grossly negligent if we did not give due attention to their significance and importance in teaching nurses whose function is so much concerned with intelligent ministration to suffering human beings.

We speak of hostility, anxiety, fear, love, dependence, solicitude, and many other things involving feeling that apply in our human relationships. Use of these terms does not help us very much.

They point in the right direction but we must understand better their origins in ourselves and in others and the effects that they produce if we would learn to deal with them so as to do our work well.

If each of us honestly reviews what goes on in his own mind and experience, he will find that he has a feeling position with reference to other people as well as what we might call an intellectual recognition of his procedural service position. "I will do what's necessary but I don't like so and so," is a frank expression of this kind of thing. A frank expression is an acknowledgement of the difficulty. Often these expressions are not made frankly and probably cannot be made frankly. More harm is likely to result in a nursing relationship when the nurse does not or cannot recognize the real state of her own feelings. The less frankly recognized, the stronger the adverse effect, because then there is less conscious compensatory correction of the effect of the feeling.

Consider the last presidential election. What won it may not be frankly expressed in any poll, was not detected by the approved testing techniques, did not appear in the public prints,—but it was tremendously strong. It turned everything over. What worked there collec-

tively works in us individually in our daily work with patients. Much might be said about it. Time doesn't permit, but I judge that Dr. Gerard and others who will follow me intend to go into some of the details of these matters. The point is that the nurse is concerned with human relationships and is trying to do her part in those relationships to help people. She is a part of a team. The nurse must not be ignorant of the potentialities of these forces inside herself and inside other people which act in this concealed manner.

Now, how do we go about seeing that she gets the understanding and experience that she needs? It requires something of self-analysis certainly. It requires an intelligent comparison of one's own experiences with the experiences of others. This cannot be obtained merely by formulating a set of questions, designed to bring out the information and answering them yes or no.

If you attempt to do that, you find there are many blind spots. It may not give you the kind of information you need. An exceedingly frank examination of self and of one's own relationships is required. Even if you do that, though, you will find that you must go further. You will have to learn also how it happens that you have this leaning or that leaning. That is not an easy job and the longer it's postponed the harder it becomes because more experience is piled up along the lines which have led to the difficulty. Certainly any answer that we may get will inevitably lead from our relationships with others in the present back to our relationships with others in the past.

We will have to explore those relationships. Now, which relationships? Certainly the ones with the deepest meanings. Those are the ones in which the force lies. I don't need to tell you which relationships in your own life are the ones that you can label as having the deepest

meanings. You can do that probably right now. You can say, "Well, I have them all labeled. I know how I got along with so and so, and so and so,—people that are most deeply important in my life, and what then? Does that give me all of the answer?" No, it doesn't . . .

I said that we had to have a frank exploration of these relationships. We have to become aware of what entered especially at the unconscious feeling level,—a thing extremely hard to accomplish,—currently, and with reference to the past. Many things that we will recognize and wish were different will still prompt us to action in the same old way. We can learn that a relationship which we had set up in our mind as being of a certain kind, of a certain quality of feeling and having a good deal of force, might turn out on close examination, to be something quite different in its significance from what we had supposed, but with just as much force acting in a way of which we had been ignorant.

We will see in our early attachments things that were not purely whole-heartedly positive feeling attachments, that had much that was negative in them. Sometimes we find that there has been a transmutation of feeling experience of some sort, that the thing that we thought we wanted and loved and liked was not the thing that we really wanted.

There are many strange turnings-over. I think it will improve our relationships with other people if we are aware of things of this kind. It will require some self-examination, sometimes with the aid of a psychiatrist. This isn't anything new, of course. It has been recognized long ago. The lives of great people give us lessons about this. We learn of people who are called great, who had almost no friends,—cold, calculating and dominating personalities.

Then there are others who have done things which have been much more worthy, people who related their experience to the experience of others in a much more feeling way. The lives of many of the saints give us this sort of a story. In fact, I would say that almost invariably people in this second category have sensed the need for self-analysis, have arrived at conclusions as to the dignity which should attach to human beings and have tried to conduct themselves so that that dignity would be observed. They have become aware of the faults and imperfections of themselves. They have attempted to correct these things in themselves, and on the other hand, have tried to help rather than to condem others for things they had found represented in themselves. They had charity and mercy. The judgments that they arrived at were almost nonjudgmental. Men cannot make final judgment of one another. We may make part judgments and we must make these judgments always with due regard to the difficulties of others and the possession by each of an individual human dignity.

I would say that every physician, every nurse, every person who has to deal with other people and render service should be aware of these things in himself and should always try to let these principles guide him as he does his work.

CHAIRMAN: Thank you, Dr. Gerty, for giving us such a fine start on this program.

Before we proceed, I would like to present to you the chairman of our Planning Committtee, Dr. Gustave Weinfeld, who did such excellent work in leading the committee in planning this program.

Dr. Gerty gave us an excellent cocktail. If this is an indication (and I am sure it is) of what the rest of the program is going to be, we are in for a very delicious dinner.

Dr. Margaret Gerard has kindly consented to give us of her rich experience and insight in the developing personality in the early years of life and to make meaningful in specific ways the things Dr. Gerty talked of in more general terms.

I am sure we all look forward to the presentation of Dr. Margaret Gerard who will discuss with us: "Personality Development in Early Childhood." Dr. Gerard.

PERSONALITY DEVELOPMENT IN EARLY CHILDHOOD

MARGARET GERARD, M.D.

Dr. Gerty has spoken to you about the importance of knowing thyself, and how essential it is to know yourself in terms of your relationships with other people. I may also add, which he certainly implied, that the quality of what you do for other people as nurses depends on what kind of person you are as well as on what kind of knowledge you have.

Intuition plays an important role in everyone's good understanding of people.

Today I am going to talk to you about how we get to be what we are, what the early years contribute to the development of personality and what those early years represent in yours and in patients' attitudes. From your own nursing experience you probably realize that many patients become a bit like they were as children when they are suffering. It is very difficult to be a mature, an independent, a brave man or woman when an individual is suffering, is separated from the persons and the places that make him secure, is afraid possibly of his future as to whether he is going to be a chronic invalid or whether he is going to die. In other words, the adult patient, particularly the hospitalized patient, often returns to childish patterns of behavior and he wants some of the

things that children want and need. He wants protection. He wants help. He wants understanding. He wants to be taken care of and it is only the very, very mature, the very independent, the very sure person who can still behave like a real adult when he is being nursed. The nurse who is able to accept her patient's childish idiosyncrasies, to give him comfort and reassurance, a bit as his mother gave to him in childhood, adds a seeming magic influence for recovery. I don't have to tell you nurses this because I am sure you have noticed it. You have discovered that when you greet the patient with a smile he often seems to gain a bit of strength for the time being. We know that in certain instances of illness in small children that the personal warmth in the nurse is essential for their recovery. We know that certain children seem to die because they are not mothered through the illness.

As you know, Dr. Aldrich's work "Babies are Human Beings" is directed almost entirely to the mothering of a baby, the mothering of a baby in terms of giving him all of the interpersonal love, affection and closeness which the child needs for growth and health.

Now from this particular point, I would like to start ahead with the actual development of the small child, keeping in mind always the fact that the interpersonal relationship is the keynote of these various points of development. This sounds as if I was completely an environmentalist and did not believe in the influence of constitutions at all. Such I do not mean. I believe that constitution plays a very important role in the development of the individual. Children vary. Children vary, as you know, at birth. They vary in their looks. They vary in their body configuration. They vary in their temperament. On the other hand, the thing which makes these individuals apparently real human beings is much less a

constitution, taking the human constitution as the basis, than the experiences which the individual has. We know from discovery that individuals who have had no human interrelationships don't develop into what we think of as human beings.

Anthropologists have examined humans who have grown up in the wild state and are discovered living among animals as one of them—like the story of Romulus and Remus. Such persons behave more like the animals than human beings. They walk on all fours or they swing around with their arms on the trees. They make sounds like animals. They don't make sounds like humans. If they are found within the later years of life they are incapable of learning human ways and never learn speech nor moral habits.

Thus, in spite of variations in constitutional differences, civilized behavior is learned from environmental experiences and learning to adapt to society with habits according to our social rules and our community needs and so forth, starts very early. It starts, probably, as soon as the baby is born.

What does this adaptation consist of? What does society demand of individuals? It demands various kinds of behavior which are concerned with community living. The child must learn to control his biological impulses. The individual is born with self-survival instincts for the purpose of taking care of himself and his perpetuation. He is born with reproductive impulses which have to do with the perpetuation of the race.

These are strong impulses. They are strong so that one can survive in spite of great difficulties and that the race will survive in spite of equally great difficulties. The individual tends to obey these impulses fairly immediately and simply as the animal does. It is education and

training which changes and modifies these impulses, that they be expressed in socially accepted ways.

The little baby, as you know, is entirely influenced by the self-survival impulse. If you watch a baby in action almost every move he makes is in terms of selfishness. He cries when he is uncomfortable, which has to do with self-survival since pain exists biologically as a warning. Pain is a warning that something is wrong relative to the good economy of the human body. Therefore, the child's instinct is to relieve pain. He cries when he is hungry; he cries when he is wet if the wet is uncomfortable and irritating; he cries if pins stick into him; he cries if his blanket comes off and he loses the comfort of warmth. He sometimes cries when he is put down because it is not as comfortable on a bed as it is in the mother's arms—a relative pain.

How he controls this self-survival impulse will depend to a certain extent upon the experiences he has. If he has all his desires immediately satisfied, the child never learns to master suffering. We find that if the individual child by three or four is still being completely indulged, he is still asking for immediate care and satisfaction similar to the little baby and cannot tolerate the slightest discomfort or postpone the alleviation of pain to a later period. From your own experience you know that certain individuals can take pain and other persons can't take pain. This may be partly constitutional to be sure, but it is probably largely the result of training. The individual who can grit his teeth and bear pain because he knows he is going to be better and well later, is a person who has learned to postpone the satisfaction. He doesn't ask for immediate satisfaction. The individual who yells and screams and says, "I won't have an injection, I would rather have smallpox," is still obeying the simple impulse

of attempting to alleviate pain at the moment he feels it. He hasn't learned to suffer pain for future gain.

The individual who wants to lead a happy life and has learned to postpone his satisfactions will say, "Well, this hurts and I don't like it, but I don't think I want smallpox either. I don't want to risk dying early and I don't want to risk having a disease which will cripple me or which will be one I can give to other people," and so forth. He has a social attitude relative to his importance in the world and to his function in the world and therefore he will control his impulse.

Now, the same thing is true in relation to the biological reproductive impulses. In society the individual is asked to postpone sexual satisfaction and to postpone the alleviation of sexual tension long beyond the period when his impulses develop. In other words, he is asked to postpone this satisfaction until after he is married, and capable of supporting a family.

Not only does he have to learn to postpone pleasure and to postpone the alleviation of pain, but he has to learn to take substitute pleasures, since many human wishes if satisfied destroy the integrity of social living; such as stealing, killing, promiscuous living and so forth.

This adaptation to society's demands, we speak of as the reality principle and we often think of it as contrary to the so-called pleasure principle. In other words, the child comes into the world, more or less, with all of his biological trends directed toward seeking pleasure and the alleviation of pain. Very early he has to learn that reality demands something different from him than the satisfaction of immediate biological pleasure.

Is the reality principle really contrary to the pleasure principle? It isn't. Very often people think of it as something different for reality adaptation is also pleasurable in a different way. The very reason that society has

developed this complicated kind of organization and has had through that organization to make demands upon the individual is partly in the service of pleasure. In other words, we live more contentedly. We live more adequately. We live a lot longer and maybe we live more happily because we adjust to reality. We as human beings could not survive a minute except in society. These odd, stray persons that I have spoken about who survive in childhood among the animals and in very primitive animal states are rare. Probably the majority of youngsters lost, the majority of children who get out in the woods and are lost, are really babes in the woods and die there. We are not equipped by nature to take care of ourselves as individuals and therefore to live we have to live in a society. So that by virtue of that need we get much greater pleasure and for a longer period.

However, the child can not know of these values of social living. Why does he then give up these immediate pleasures? Why then does the child when he is too young to reason and to know what the future may offer accept postponement or sacrifice? In general, there are several motives, two of which only I will discuss in any detail. One motive is the need of a different kind of pleasure than that sacrificed and the other is the wish to alleviate the pain and suffering which the individual incurs if he does not give up the pleasure. For instance, the pleasure which the child gets instead of satisfying his hunger at the moment that he needs food is the pleasure of the warmth and affection and tenderness of the mother. In other words, the child will obey the mother and wait for food because the attention and love which the mother shows is pleasure to him, and a pleasure he dare not risk losing.

He very early begins to inhibit instinctual action because when he doesn't do it, the mother smiles at him or

pats him on the head or caresses him. In other words, the pleasure of that interpersonal relationship is very essential for the emotional development of the child. The other, pain relieving, has to do with the displeasure of the mother. The child will not do things because he senses the displeasure of the mother. When the mother frowns at the child, he learns fairly early to recognize that frown as a point of separation rather than a point of closeness. Therefore, the show of displeasure on the part of the mother is an experience which the child very early and almost instinctively attemps to avoid along with the attempt to avoid physical pain.

Actual physical punishment may influence the child to change his behavior and even the fear of punishment will make the child change his actions. The small child who is punished, however, may not know why he is punished but he knows that when he does certain things inevitable suffering ensues and therefore he stops doing the certain things to relieve the pain. It is interesting that learning from fear and pain often simply inhibits and dams up instinctual energy, while learning from the wish to gain love through pleasing the mother redirects the energy into substitute and socially acceptable activities. He keeps expressing himself and he keeps all his potentialities working. The child who must stop and inhibit himself because he is afraid is the child who develops the so-called inferiority complex. An inferiority complex grows out of the need to inhibit activities from fear. People develop all manner of inhibitions; they can't do this and can't do that and can't do the other thing because they feel inferior and feel inferior because what they feel that what they are doing is wrong and what they have done is wrong. And it is a vicious cycle that goes around and around and around and we psychiatrists spend a large amount of our time trying to

undo what parents did in these early periods when they inhibited children and developed inferiority attitudes and made it impossible for the individual to live up to his actual capacity. Thus the incentive of fear, the incentive of suffering is not a developmental incentive. One may have to use it occasionally. There is no question that the child has to be punished. The child may have to be warned that he will suffer if such a thing is done, but certainly in terms of developing the greatest capacity and the greatest usefulness, the incentive of satisfaction in personal relationships is a much better one. In terms of punishment, my own feeling is that the small child as well as the older child needs punishment if he is properly treated in the other relationships only when he is going to do something which might be very dangerous about which he doesn't know. In other words, take the small child who sees a pretty flame. The automatic reaction of the little child is to put his hand in to feel it. To protect that child from burning himself severely one has to stop him quickly. One can't stop him quickly by saying—"Please don't do that," and smiling serenely at him so that he has the pleasure of one's smile at the moment. One may have to stop him quickly and maybe one has to slap his hand to stop him. Maybe one has to grab him back and give him fear to protect him from actual harm.

The same is true of other harmful things. Sometimes these harmful things are in relation to society. The child may have to be punished when his satisfaction in relation to self-survival is hitting his little brother over the head when his little brother takes a toy and he wants the toy or maybe the little brother takes his food and his plate is left empty. The first wish he has in the very early periods is to interfere with that and to change it, get

rid of the brother the best way he can, hit him over the head, knock him down and then one can grab back one's food.

Now, the child has to learn very early that kind of anti-social behavior is not acceptable and sometimes the child has to be punished to stop him soon enough before he has injured his little brother. Little children act often as though they really have murderous impulses toward their siblings.

In the very early period of life, the need for affection from the mother is understood by infant nurses much more clearly in this generation than formerly. It is from such experience and knowledge that Dr. Aldrich's book, "Babies Are Human Beings" was conceived. In other words, he has found that the child grows better physically, grows better emotionally, grows better morally, if his relationship to the mother is good and is pleasurable and they both have fun out of it.

The child needs to have as little suffering as possible during these early periods because he must not inhibit himself too much and spoil his potentialities. Therefore, out of this need has grown the attitude: Let the child feed himself when he wants to feed himself, and thus has come the change from the rigid four-hour schedule, to the so-called demand schedule. Now, satisfactions other than those of relieving hunger as it is felt, are important and those are the satisfactions of less specific body feelings. The child very early responds to the handling of the mother. The old fashioned cradle was probably developed intuitively by our ancestors because the child who was rocked seemed to get on better than others.

I have an old cradle that I picked up in an antique shop in New England. I wish I had had one for my own

children. This is a rocking chair to which the cradle is attached. The cradle attaches to one end of the rocker. You may have seen one of these. A mother while she was sewing or whatever she was doing, while sitting could rock back and forth and the child rocked back and forth too and there was interrelationship which had to do with the movement and closeness and body satisfaction.

The child needs also to be caressed. That has to do with his growth experience and may have something to do with the continuation of his intra-uterine position. In the uterus he is caressed. He is inside of something that touches him on almost all sides and it keeps touching him while he is rocked by the mother's movements. So this need for body contact and rocking undoubtedly have to do with the continuation of intra-uterine satisfaction.

It is essential for a nurse who cares for an infant who is ill to understand these needs of the baby. For when the baby is ill and suffering, and away from the loving mother, only the nurse is there to give him the experiences he needs. The baby can't have a mother but the baby can have some tenderness and understanding from the nurse. Now, the good infant nurse automatically is warm and tender, that is, she will smile as she leans over a baby. She will handle it carefully rather than roughly. She will also hold the baby for nursing, if there is time in her busy schedule.

A very good example of what happens to the child who is just left and handled only for feeding and nursing is shown in some observations of Dr. Spitz of one of the S.A. orphanages. He has movies of the babies which are very dramatic.

These were illegitimate babies who were eventually to be separated from their mothers, but those mothers

who were willing to stay with the children and nurse them were asked to stay and they lived in and were given jobs in the hospital.

When their infants were two years of age—maybe a little earlier—these mothers were expected to work, and therefore, they lived out.

Now, the majority of these mothers got jobs and went away and separated themselves from the babies, but others didn't. Others lived out, got their jobs, but came to see the baby, to feed the baby, play with the baby, to be a mother as much as possible for one who was a working mother. The other babies were taken care of by the personnel in the institution.

He shows pictures of these babies up to about 24 months and you can't see the difference between what we might call the deserted ones and the normal ones—up to two years these children are exactly the same. They develop equally well. They are gay and happy, they eat well. At six months later, the babies who have been neglected, as compared with the babies whose mothers have continued contact with them, have already retrogressed so that they have lost their walking capacity. They don't feed very well. The look undernourished. They look like babies with marasmus. These babies don't learn to talk. They learn to make certain sounds. Their interpersonal relationships are bad.

They don't pay very much attention to a person. Later, by the next six months, those babies are already beginning to be anxious about people and beginning to withdraw so that when a person comes near and leans his head over the crib, the baby cries and squirms if he gets too close.

The mortality is terrifically high among these neglected babies. It seems magical that a mother's love can make the difference between a wish to live and a wish to die.

I speak of this particular period in such great detail because, in nursing either a child or an adult, one must remember the needs of this period since the person in great stress reverts back in his feelings to this early period. We know that many soldiers under shell fire or soldiers away from home injured in the hospital called in their delirium on "mother". For many of these men their mothers had been dead for some time. They may have had wife and children and other loved ones and had established an independent life. Why did they call mother? Because the suffering reverted their feelings toward the one who had soothed them in times of helpless childhood suffering. Time after time we find that an individual under terrific stress, pain, suffering, disaster, reverts to the longing for that kind of care which he had at a time at which he needed it, when he then also was suffering, when he then also needed to be taken care of because he couldn't take care of himself. Knowledge of this tendency as a human tendency can make a nurse more tolerant of a very "ornery" and unpleasant demanding patient if she realizes that his behavior is an automatic attempt to gain relief from his suffering.

People vary in the amount of babying they ask for. Sometimes, the individual who has had least satisfaction in his babyhood is the one who is most demanding. He never has had the security of true comforts and, therefore, when he is threatened and suffering he has no resources within himself since these resources grow on the basis of a good relationship with a protecting loving parent. Hence the patient who is acting the most babyish is the person who suffered the most during the time when he should have been taken care of and cherished.

A well cherished child can gradually enlarge his circle of persons upon whom he depends. He learns to rely upon older brothers and sisters, upon his father and

upon familiar persons at school. However, it is important to remember that during all of these early periods, the mother is still essential and the child feels hurt and unsure in periods of separation. It is as if you took his props out from under him when he enters the hospital, and this experience we speak of as the trauma of separation.

If his fears and discomfort are understood by the nurses caring for him, he can depend upon them as a substitute mother, and thus make a step forward in enlarging his circle of relationships, and mature further toward independence. If he is not understood and is rejected, this trauma may leave a psychic scar.

Gradually a normal child begins to develop social habits within the framework of his mother's love. He begins to eat every four hours, he no longer cries if he is slightly hungry or if he wakes up at night, he is willing to postpone various other kinds of pleasure. All good habits begin on first experiences and then are repeated as a result of a biological tendency. As a result in subsequent situations of stress this tendency tries to repeat what worked before in alleviating the discomfort. This tendency to repeat fixes good habits, but it also fixes bad habits and these bad habits may remain as symptoms. The child who has learned that he gets his mother by screaming and yelling will tend to repeat screaming and yelling whenever he attempts to get something pleasant. The fixation into a character pattern of bad habits is at the basis of all of our severe disturbances in later life. A neurotic symptom becomes a method of adjustment to living rather than a socially creative action. If we give the child the right experiences, his repetition compulsion will fix those habits into good personality attitudes and behavior.

The business of real satisfaction in more adaptive behavior patterns is important. In other words, the child who has gotten satisfaction from breaking things apart gradually through the experience of living with the parents, learns there is a lot of satisfaction in building things up, so this satisfaction is more creative. Gradually as good habits are fixed he relies on himself and he does not need to depend so much for security upon the mother. He learns that there are wells of capacity within himself for satisfaction and he seeks those satisfactions.

Imitation is also a very important factor in initiating good habits. The child learns early as I said to postpone pleasure. He learns also to postpone being a big person. If you can put yourself in the place of a little child, you realize how many advantages the big person seems to have to the little child. The little child doesn't know all the problems there are to being an adult and being responsible. He knows only of the advantages of being out late, of being able to eat what he wants, when he wants to, the ability to buy his own clothes, and concludes that being a grownup person means having all the nice things of life.

He learns early to postpone those pleasures of adulthood but in the postponement he attempts to get ready for them by imitating the behavior of the adult.

At first he fumbles in his imitation. He copies the outward signs. At first he may imitate by putting on daddy's hat and his pipe into his mouth and taking his cane and strutting around the house and saying, "I am daddy." But that's just the beginning and that's a good sign. That means he is thinking forward to being like daddy and gradually he will learn other things which daddy does such as eat without spilling, fall without crying and so on and on.

Before I go on to the discussion of the next infancy period—theoretically what I am supposed to do today is to take the child up to the school period and others will follow on from there—I think I should discuss a point about role of the mothers or nurses personality in her success with children during this period and later.

I have told you about the child's needs, but it isn't always so easy to satisfy them. It takes a content and well adjusted individual to be sensitive from hour to hour and day to day to another's needs. It is important, I think, for us to help the mother understand just as we try to help the nurses understand that a happy individual is much more capable of giving happiness to other people than a person who is unhappy and dissatisfied. What we find with the individual who is dissatisfied, who feels frustrated herself, is that she becomes very self-centered. She is unable to give. She is unable to do the things spontaneously which are really indicated and thus often deprives her child in spite of her good intentions. Thus, it is often necessary to encourage a mother or nurse to enjoy herself. We often hear that mothers are better with their second child, their third child and so forth, than they were with their first child. Why is that? One reason is that the mother may feel an exaggerated responsibility in the care of her infant and if she has fun in the work she feels that she is not serious enough and asks herself, "Should I enjoy cuddling my baby or should I really think only in terms of what this baby needs?"

The same situation may be true relative to flexibility in routine. She begins often with the fear that her natural impulses cannot be correct and therefore she takes on rules and rigidity which makes it difficult to be flexible in her routine. She can't stop making a dress for Susy for example, when Johnny is frustrated in building blocks and needs a little help and encouragement; needs her to

sit down on the floor with him and put a block in place. In other words, being a good mother as being a good nurse, means responding to emergencies in a very flexible way, which means one must not become fixed in routine so that out of routine one loses one's self contentment and is uncomfortable.

This capacity for flexibility, the capacity to enjoy pleasure in one's work is often the result of a rich and satisfying life. It is essential to have enough outside pleasure so that one doesn't have to have all one's pleasure in one's work.

I can remember one mother who said to me: "Can I really enjoy my child?" This was a mother who was brought up to follow very rigid routine in child care, what, in the old days, we called Watsonian training. John Watson, the psychologist who advocated training by "conditioned reflexes" encouraged parents and nurses to handle a child as little as possible, to refrain from caressing and loving so that "mother fixation" and dependency be avoided. As a result many youngsters developed symptoms of severe emotional deprivation.

And we must pass now to the next stage of development; the stage in which his arms and his legs can move more coordinately. He learns to grasp things. He learns to walk. He learns to control himself more adequately in various ways. It is the period in which social training begins, at the same time that training for control of biological functions such as bowel and bladder excretion is instituted. This is thus the period in which habits become fixed, particularly habits relative to self-control; the period in which the child really is faced with the necessity to control and to postpone biological comfort. If you see a little baby excreting he seems to show pleasure. In other words, there seems to be some pleasure in the actual passage of the warm stool through the anus. So

that when the child learns to control excretory activity he is on the first steps toward social adaptation. The same thing is true in relation to urinary control. The same thing is true in relation to muscular control. He has to learn to inhibit and modify his body movements. He can't throw everything he wants to. He can't hit when he wants to. He can't kick when he wants to. He can't go when he wants to. He has to learn to operate within a framework of control and activity which is safe for him and for his environment.

It is important, during this period, to not expect more of the child than he is capable of. One of the serious mistakes relative to this idea of rigid routine was the attempt to train for excretory cleanliness too early. We know now that physiologically the child isn't ready for excretory control as early as we used to think. The child's sphincters are not innervated completely enough for voluntary control until he is seven or eight or nine months of age. As many of you may remember, pediatricians encouraged mothers to start controlling the babies with suppositories at one or 2 months of age. With this early beginning relapses often occurred, or constipation became a problem. If one waits until the child's innervation is completed, the child can really control his sphincters and really attempt to be clean. The child learns very quickly. All that is necessary is tell the child what is wanted and if the mother has a good relationship to the child, he will obey because he wants the mother to be pleased, and he gains pleasure through the mother's pleasure.

Of course, it is true that sometimes children regress as a result of illness. A child, who in the half training period has a severe diarrhea, may regress because he is incapable of holding back the diarrhea. The failure

gives him a feeling of inadequacy and he remains regressed because he despairs. In such a situation, the child needs patience and retraining.

Now, the important phase of this development is that of teaching the child habits within the framework of flexibility. It's the hardest thing in the world often to recognize the fact that the child needs a little leeway. He mustn't turn all of his energy into self-control and rigid routines. He must have some energy left for later constructive activity. In other words, he is going to need a lot of other things in life beyond simple control of himself, simple living up to the routines which he must do at this period. Therefore, the parent as well as the nurse must know within what framework can this child be allowed to operate. He can be allowed to operate with a little bit of misbehavior, with a little uncontrolledness, maybe in going to bed on time, a little indulgence when he wants something, a little slipping now and then relative to self-control, a little temper outburst when he feels terrifically angry and so forth.

What happens if the child doesn't have an adequate amount of leeway so that he can have energy left for new and more adult adaptive mechanisms? He becomes so rigidly routinized that as he becomes adult he can live only within a routine schedule. Certain individuals are compulsively routinized and these go to pieces in emergency, and develop frank neurotic illnesses. As long as they are within the framework of rules, they can live, but in new situations they feel lost.

The child enters the next period supposedly with good habits. If he has been well taken care of, if he has been well loved and therefore his security is good, if he has been taught well so that he wants to do the things that are supposed to be done and yet feels capable of experimenting with new things and taking on new habits

and new experiences, he enters the next phase which is a much more independent phase.

The child at three, four and five is in the stage at which he ventures out of the family circle and begins to make closer relationships with neighbor and school friends. He also becomes closer to his siblings and the other members of the family. The little boy discovers his father and that he is important. He isn't just the person who comes sometimes and interferes with the relationship to mother. He isn't just a person who can give or take away benefits but is a person whom he would like to be like, who has similar kinds of interests and with whom he must learn to share his mother as well as the other siblings. So the child learns at this period to share.

He learns to share companions. He learns to share the father or at least share the mother in relationship to the father. The little girl learns to share the father in relationship to the mother and also share the mother in relationship to the father. The development with the little girl is different because she continues to have a very close relationship to the mother and wants to be like her but is branching out in a closer relationship to the father; whereas the little boy is wanting to be like the father.

This change follows another physiological development which is very important and which is tied up with the endocrine development, that is, the development of the sex organs which obviously are premature at three, four, five years of age, but in which there is an actual stepup in hormone which is not comparable to any extent with the stepup at adolescence but has a very important role in developing the child's attitude.

The little girl begins to feel like a little girl and in her identification and attempt to imitate the mother she has this feeling like a little girl and not like a neuter. Up

to that time the children feel much alike. The same thing is true of the little boy. The little boy feels like a little boy and he has much more of an intensive desire to be like other boys, to be like the father, like other men. His interest in sex differences occurs at this time and it is perfectly true that sex curiosity is at its height.

If the child has his sex questions answered relative to differences, relative to functions and so forth, he gradually accepts sex functions as natural just as he has learned to accept all the other knowledge. He accepts it and he puts away such interests as childish thoughts and goes on towards the development of more independent and greater skills.

Also at this period he has not only a curiosity as to differences, but a curiosity as to relative importance. The little boy may think that the little girl is inferior with her less visible equipment, or that a larger boy is superior. Sometimes the little girl feels she is inferior. Therefore, often the handling of the organs at this period is not so much a result of interest in terms of sex sensations because the sensations are minimum relative to later development, but as a result of curiosity. The child handles himself because he is wondering what he is like or whether he has adequate parts just the way he handles his eyes if he wonders what his eyes are like, or questions their value. If he sees another eye that looks different from his, he puts his hand up to his eye to see what it is like. I can remember that in relation to a little child who developed an eye tick. He saw a man with an enucleated eye and immediately put his hand up to his eye. From then on he kept wondering all the time if he himself really had an eye. He had seen this person without an eye and developed an unsuredness about himself which is similar to little boys when they look at little girls. So he kept putting his hands up to his eye which

movement became a true tick, for which he was brought to me by the mother who said, "I can't understand. I tell him not to. I tell him to stop. He keeps doing this, particularly when he is anxious." It merely started as a reaction to seeing the other fellow without an eye, and his curiosity about himself.

So at this particular period the child goes through certain reactions which are going to be very paramount in relation to his later adaptation. The way the parent handles the knowledge, the way the parent gives information, the way the parent accepts and recognizes his curiosity relative to exploring his parts and does not feel that it is a result of something evil, will determine his ability to accept himself as adequate; he has no evil intent at that time any more than any other curiosity has evil intent. Curiosity is the thing by which we learn and by which we are able to later adjust and later carry on our professional activities.

CHAIRMAN DE BOER: Thank you very much, Dr. Gerard. At this time we will have the movie, "The Feeling of Rejection." I suspect that some of you have seen it, but you are invited to see it again. The movie, "The Feeling of Rejection," is the portrayal of the life of a young lady who went through some of the experiences Dr. Gerard talked about and didn't do too well. It shows how she is reacting to life with a sort of "inferiority complex," if you will, and there are throw-backs to her earlier life experience which indicate why she developed the way she did.

I think you will be interested in it and will find it makes some of these theoretical concepts more realistic.

(At this time "The Feeling of Rejection" was shown.)

CHAIRMAN DE BOER: The meeting is adjourned.

THURSDAY AFTERNOON SESSION

November 4, 1948

DISCUSSION GROUPS

DR. ROBBINS: The purpose of this particular group is to assemble the material of the discussions which have taken place in the separate groups, and bring about some order out of the chaos. We will start with the recorders and have them give us a brief resumé.

Recorder for Group 5:

We discussed many different points along the line, mental health and relationship to nurses training itself, bringing out the point that in many schools it was introduced in the preliminary period and carried on there with the social and health aspects along with each subject taught. The student correlates them in her work.

A discussion followed in regard to the teachers themselves, their purpose toward the work, whether they are doing their duty toward the environment and the pupil also, the general approach of the instructor to the nurse and the consideration of the patient, her conferences with the students—individual conferences where problems arise—demanding more attention from the psychiatric aspect, and the introduction of the student to some counselling along that line. Many schools do have such a counsellor who is there for the students, and many students are allowed to contact the psychiatric counsellor. Others where such a counsellor was not available were handled through the school office.

Discussion of length of nurses training resulted, and was still a debatable question, but it does demand attention from standpoint of mental hygiene. Discussion was ended with rather a short discussion about the ma-

turity of the student and her relationship, as far as maturity in her profession and in her social activities beyond training are concerned.

Recorder for Group 1:

Our first consideration was to define the purpose of our meeting here today. We felt our purpose was to help us understand the student nurse, to help her become a well adjusted individual, who in turn can render better nursing care to patients in both their physical and emotional needs.

As a first point, it is very important to be selective in type of student coming into a school of nursing. Selectivity would eliminate many problems and do a better job in nursing with the group we have.

Also considered, the students who withdraw, and where our responsibility lies in further counselling and work with students.

We considered the need for developing the student as a total individual when she becomes a member of our school of nursing. We considered the staff working with the student, and the suggestion was made that we might plan an in-service education program not only for the school of nursing, but also for the staff of the hospital so as to have a better understanding of the staff members as persons. It is a good idea for the staff to have an adequate understanding of young people.

In our last analysis we felt much has to be done in the philosophy of nursing education; with fewer hours of work a student nurse has more time for leisure and other interests beyond learning the techniques of nursing care, and with some further preparation and planning with the people in nursing education, we can do a better job.

Recorder for Group 3:

We discussed briefly a point from Dr. Gerard's lecture and decided that the pediatric nurse plays an active part in the prevention of mental illness, and her training and preparation should be directed toward developing principles of good mental hygiene.

We also talked about how we could prevent tension in the students in the pre-clinical period when they often are so shy and distressed in the nursing arts class room. It was felt that some of this tension could be prevented by the approach which the Director, the nurses and the faculty made to the student on her introduction to the school on her first day. Rather a maternal approach might be made since the student was so recently separated from a home situation in which she felt very secure, and then coming into a big institution tension would be created, and tolerance on the part of instructors would be a helpful factor. The instructor should encourage and show approval. There should be less criticism and more help on the part of the instructor. A good orientation program would also off-set some of this tension, as would the trend toward less regimentation in schools of nursing. It was felt also that rote learning destroys initiative, and very often very strict regimentation gives the student a wrong concept of therapy and she is moved by fear rather than by desire to accept responsibility.

Then student-faculty co-operative movements were discussed, and the question was raised as to how far the faculty should go in allowing students to administer penalties. We also discussed rules and regulations found in nurses' residences as compared with those found in college dormitories, and as a whole there was not too much difference found nowadays, but any seeming rigidity and strictness in schools of nursing was necessary be-

cause of health, and hours, as well as the responsibility of nursing students in taking care of human lives.

Then we discussed whether or not 18-year olds in schools of nursing were very much different psychologically than 18-year olds in the ordinary college or university, and mention was made that perhaps there was less economic and functional security in schools of nursing than in other types of colleges.

The need for relating herself to people was one of the qualifications of a prospective nurse, and she sought it there rather than in college.

Regarding the advisability of compulsory study hours, it was felt that too much would destroy initiative and development of responsibility. Finally we wondered just how students, who have come through a progressive system of education where they have a great deal of personal responsibility for their work, are going to adjust to the more rigid curriculum in schools of nursing necessary because of the very nature of nursing itself. It was felt not much can be done but offer good guidance and counselling programs which would help to off-set it.

Recorder for Group 6:

Our initial comment was that Dr. Gerty's and Dr. Gerard's talks this morning were excellent in their application to nursing education.

Our first problem was whether or not student nurses were mature enough to use lectures in psychiatric nursing and mental hygiene as such, and it was generally agreed that pre-clinical and beginning nursing students did not know enough about life itself to apply the principles generally to the patient at the beginning. They do not relate properly to patients. Further lectures on mental hygiene as such should not be the formal type at the beginning, but should be integrated with all forms of in-

struction. The psychiatric approach should be inculcated in all classes and then give psychiatry in all units. The problem was one of interpretation; first of all, a nurse should interpret herself to herself. Secondly, a patient should be interpreted to the nurse and the application made from that point. The suggestions for doing this were counselling, and especially better interpersonal relationships between teaching faculties and the student nurse. It was agreed that the fault for misinterpretation and lack of application on the part of the student nurse often lay with the faculty. They thought the faculty sometimes were only interested in the physical aspects of illness, and sometimes the faculty were doctors teaching student nurses and they should integrate their psychiatric knowledge with physical and medical knowledge, but did not. The problem of interpersonal relationships was discussed at length. An analogy was drawn to Dr. Gerard's subject of transference. The problem was then decided to be one of interpretation, and it was decided there was a need for someone to interpret to the student or get the student to understand.

Another problem was how to get at the student for the purpose of getting to know her and solve some of her problems and solve some of the instructors' own teaching problems. It must be done in the pre-clinical period. Stress was laid on the fact that the faculty might be at fault in that they are not particularly interested in the emotional life of the patient sometimes, nor sometimes of the student nurse. They do not see the correlation in their teaching processes.

Then we decided on how to get acquainted with students so we can better relate the staff nurse to the student. Suggestions were for tours to foster more friendly relationships, and staff conferences wherein the staff nurse was educated to the point that work out-put was not the

primary factor but education was. Clinical ward teaching was a very good opportunity to utilize the co-operation of the staff nurse. It was decided since students must follow rules, and graduates were students at one time and now are in a position of domination, that this was the positive factor for much poor interrelationship, and the group decided the reason for this was that some graduates are emulating their predecessors. Possibly sibling rivalry was one of the analogous situations, and another interesting point was that during the war the old graduates were learning from the student and the situation was a much poorer one. Students foster the maternal instinct in graduate nurses, which has a better reaction than sibling rivalry.

Our final discussion centered about the staff nurse being the underprivileged person. She was never questioned insofar as her likes and dislikes were concerned, and it would be a good thing to have a conference, including her as part of the instructor group and consult her as to her likes, etc. Also extra activities were considered. This would further better interpersonal relationships.

Recorder for Group 4:

The problems discussed in our group were very similar to those given in the preceding reports. There was felt a great need for some type of test which would enable the school to determine whether or not the student had personality difficulties so that such students could be screened and not allowed to enter the school and then be subjected to the trauma of having to be dismissed. Also there should be some means of follow-up for students dismissed because of personality difficulties so they might be helped.

There is much misunderstanding about help from psychiatrists. There is a tendency to resist any suggestion that a psychiatrist be consulted. It was suggested that if we had more meetings such as this some of these problems could be handled better. And the attitude of the head nurses and supervisors toward some of the students' problems tended to intensify and exaggerate them. It has been noted that help has been obtained from psychiatric affiliations, and it was observed that a student who had a psychiatric affiliation, returned to her home school with a better attitude and better understanding of her own personal problems. It was suggested that mental hygiene not be taught as a separate formal course, but that it be an integrated part of every course, particularly obstetrics. It should begin when the student enters the school. Psychiatric help should be available for students. Students should be made to realize that their emotional problems are common to all and not peculiar just to them. There should be a competent counsellor to whom the student could go.

It was also pointed out that in the pre-clinical period the student must carry too heavy a load. These girls are adolescents and they need more time for play and rest, and there is no time for that. There should be facilities available for informal recreational activities, not depending entirely upon planned programs for large groups. Some students are very timid and very unhappy if they must participate in large group activities and need more provision for home-life activities. There should be included, particularly in the pediatric courses, more time for study of child development. The psychology course is short, many just 30 hours, and there is much given in this course not particularly applicable or needful for the student. If more attention and time were given to the study of child development, personality development,

how to work with patients, people and one another, some of the problems might be eliminated. Suggestion was made that some changes might be made in the pediatric assignment, and one nurse reported on a method they were trying out in their particular school, where the student was assigned to care for the child over a longer period of time and not rotated so rapidly so as to take care of every type of illness. That she would have more time with one individual child, so the nurse-child relationship would be a more satisfying one for the child. Then the school nurse pointed out the need for this attitude toward young children going into kindergarten, and first grade, where the separation from the mother and the home was very often difficult for the child. And with a better understanding of the results of the right or wrong environment, how it affected the child and the adult, if the student recognized this, she would be more tolerant and understanding with the difficult sick person in the hospital.

Students reflect the attitudes of their head nurses and supervisors. So it is important for head nurses and supervisors to become acquainted with these problems and needs. It was pointed out that more continuity in caring for any patient was necessary. Where the nurse was assigned to the care of one patient over a considerable time, there would be need to guard against too great an attachment which might be harmful to the child.

It was also pointed out that the public health nurse was a key person in the community. She should begin with the pre-natal period in teaching the mother her responsibility toward the child and in the O. B. Department so that she would go all the way through from the beginning.

Then in relation to ourselves, it was believed that if we had a better understanding of the importance of the

early environment and the early interpersonal relationships, we would be able to recognize the cause of some of our own personality problems and be able to make a good self analysis and help ourselves.

DR. ROBBINS: There is one more group, but we will not hear from them. What they have to report has already been discussed.

You have been quite active and thorough in your approach to the problems presented today. It has been a revelation to me to hear how you, the faculty, have been able to criticize yourselves. While waiting for this session to start, one of the persons attending one of the groups approached me and said that she felt the doctors were a little impatient with the nurses. We didn't understand the deep-seated problems. What she meant was that we did not take into consideration the problem of tradition. My feeling was that we may be a little impatient, but only to stir up some changes in this tradition. Nursing is a very traditional kind of profession, but so is the Army, and recently they have changed a very important tradition. Sergeants are no longer allowed to swear at Privates.

The general approach, as you have seen, is really an approach not to the student nurse, not to the graduate nurse, but rather to the patient. I think all of you understood this, but very little was said about it. What you are trying to do is improve the nursing profession so the patient will benefit. The approach was really a double one. First, how to approach the graduate nurse herself, what to do about her problems and training. Then there is the approach to the student; what can be done to utilize her capabilities to the fullest extent; how can her instructors better understand and fulfill some of the student's

needs so that her conflicts will be at a minimum and thus allow her to be a more productive student.

To summarize briefly, first the question of tradition, the fact that the graduate nurse had to feel she is a superior person, is a strict taskmaster, and that discipline must be maintained at all costs. Many of the graduate nurses have the feeling that they can correct students, that they are there to be punished if necessary, though seldom do they think of saying something kind and constructive when the student has performed a task well. Many of you have felt that this would tend to spoil the student. Today you have learned that this is not true. The approach really is a maternal, protective attitude. The student should be made to feel that the instructor really is someone who is trying to help and understand at the same time she is teaching. With this approach, the student will feel more accepted and part of the group.

Many graduate nurses tend to forget their own mistakes and are intolerant of the mistakes of students. The student is faced with many new problems of adjustment. Frequently this is the first time they have been away from home. They have just left an environment where they have received love and affection, and then are brought into this environment where they do not know what to expect. The important thing is to make them feel accepted, part of the group, and that they will be appreciated for their work, and not just punished for their mistakes.

There was some discussion concerning a more adequate approach to the selection of students. I will not go into the discussion of this. Some points were very interesting, such as selection by use of examinations, by a council, etc. These are things which would be important for you to work out yourselves. It presents interesting possibilities.

Another subject considered was a more active participation and indulgence of the students in extra curricular activity. Some of you felt that by participating with them in parties, dances, hikes, etc., that the student could be better able to accept the instructors as individuals much like themselves. One of the groups brought up the question of a nurses' council. This is something for you to discuss in more detail.

I would like to say again that this has been a very stimulating experience to me and I feel it has been to all of you. I hope that the next two days will bring many answers to your many problems.

FRIDAY MORNING SESSION

November 5, 1948

The meeting reconvened at nine-forty o'clock, Dr. Gustave Weinfeld presiding.

CHAIRMAN WEINFELD: Good morning and welcome here again. I hope those of you who are making an acadamic holiday of this meeting had a very pleasant evening last night and are coming to the resumption of the Institute refreshed and ready to continue.

A great deal of thought and energy has been devoted to the organization of this program. Our original problem was to decide what group of professional people were in a position to (most effectively) utilize the newer concepts of mental hygiene in their day by day work. Having decided upon the Nursing Profession, our next problem was the selection of a faculty for the Institute. We dared not hope that our original selection of speakers would all be able to accept our invitation but fate was generous to us and you. The result being that when this Institute is ended you will have heard national authorities in their respective fields. We are deeply appreciative to them for giving us their time and their knowledge.

Yesterday you were privileged to hear Dr. Gerard speak to you on the dynamics of emotional development early in life and the clinical implications of those dynamics. I think you all gathered from what she said that one cannot isolate chronologically these various phases in development because what happens in one phase is partly the result of what is experienced in earlier phases of an individual's development and also the phase doesn't end just there but the individual goes on living

and goes on growing during childhood and he carries with him into various other phases of development the character structure that he acquired during the earlier phases.

The topic assigned to Dr. Vander Veer, Personality Development in Late Childhood, is broad because it includes that which has gone before, that which is occurring during this period and the relationships of these factors to that which will follow in adolescence. Rather than attempt to cover this large subject in his allotted time Dr. Vander Veer has chosen as his subject "Psychopathology of Physical Illness and Hospital Residence." This subject is certainly well chosen as far as those of us here are concerned.

Dr. Vander Veer is Professor of Psychiatry in the Department of Pediatrics at the University of Chicago and is also on the faculty of the Institute of Psychoanalysis. I won't say any more in the way of introduction of Dr. Vander Veer except that I, too, have sat at his feet and have learned a great deal from him. It gives me great pleasure to introduce Dr. Vander Veer.

THE PSYCHOPATHOLOGY OF PHYSICAL ILLNESS AND HOSPITAL RESIDENCE

A. H. Vander Veer, M.D.

Although this presentation is focused on the emotional reactions of the sick child, the principles involved can be applied to the management of adult patients also. The chief difference between adult and child lies in the fact that the former usually can deal with his external situation more adequately and can conceal his internal problems more effectively.

Some knowledge of normal psychological development is basic to an understanding of psychopathology. Experts in the field of child care agree that emotional

growth occurs best in a soil containing certain nutritive elements; love, protection and encouragement to independence and self-reliance in accordance with the child's individual developmental capacities. (The adaptation of educational techniques to the child's growth potential is of particular importance in weaning and toilet training.) In addition to these basic requirements, every youngster needs to have set before him consistent standards of behavior suited to his age and practiced by his parents. Rooted in such a soil, the child grows up by taking over the parents' social standards into his conscience, thus gradually acquiring the capacity to master infantile impulses, like sucking, soiling, biting and selfishness. This process is a conflictual one because the individual wishes of the child are always somewhat at variance with social mores. Self-control is achieved only at the price of creating some inner hostility, which is usually barred from direct expression by the developing conscience. The central problem in emotional development involves the relationship of the ego (or executive part of the personality) to three different factors: the conscience, the child's wishes for satisfaction and the pressure for adaptation exerted by the realistic situation in which he lives. The ego must try to gratify all these forces in some harmonious way. Mental health can be defined most simply as a state in which the individual performs this job smoothly and comfortably. He satisfies his impulses as well as the dictates of his conscience and he meets successfully the requirements of the external situation—all without feeling overwhelmed from any side.

Emotional ill-health, by contrast, in its initial stage, is simply a disturbance in equilibrium in which one of the forces confronting the ego is too strong or the individual's capacity to deal with it too weak. Some degree of disequilibrium is universal and is easily pro-

duced in small children because they are dependent on their parents' emotional support for help in coping with these three sets of influences. The first symptom of psychological decompensation is anxiety, an unpleasant emotion which arises whenever an individual feels threatened, either by his impulses, his conscience, or by the external situation. The various kinds of anxiety and the mechanisms used by the personality to combat them should be known to all who deal with the sick.

The simplest type is that produced by contagion. It is exemplified in the child who becomes frightened when he is in close contact with frightened adults. If those who should function as protectors are disturbed themselves, a child will absorb their uneasiness as quickly as if it were a highly infectious disease. The mechanism involved seems to be a weakening of the child's ego by virtue of the fact that adults no longer supply the support he needs in order to function well. This type of "communicated" anxiety was widespread in England during the war. In the bombings, it was found that a child might be exposed to the most hazardous events without feeling at all disturbed, if the adults with him only remained calm. On the other hand, a child would develop an acute anxiety state after an experience that was objectively harmless if the adults in charge of him were scared. Anna Freud has published numerous illustrative examples of this type of fear in her little book "War and Children." The practical conclusion to be drawn from such material is this: persons in immediate contact with a sick child—parents, medical staff, and nurses—must not be frightened, either by the child's illness or by anything else. If they are, it is best for them to withdraw from the situation before their anxiety is communicated to their charge. This consideration is important in the regulation of visits to hospitalized children.

The second clinical variety of anxiety is fear of injury by some external power: it is very common among children in the clinic or hospital, where so many mysterious objects and painful procedures are encountered. Needles, operations, bandages, gowns and medical jargon create the expectation of being hurt, often in a mutilating, destructive way. Limited in ability to comprehend the rationale of medical care, the immature mind easily elaborates such unfamiliar sights and sounds into dangers much worse than they really are. The same thing happens with adults when they see machinery in the hospital that they do not understand, like the electroencephalograph. The unknown always seems dangerous to all of us.

Fear of injury is often increased by events that predate entrance into the hospital. In trying to enforce discipline, parents often use the doctor as a bogey man, and children who masturbate are told, not infrequently, that their genitals will be amputated as a punishment. A child who has been subjected to threats of this sort quite understandably looks at physician, nurse, and office through fearful eyes. Unfortunately, when a child misbehaves in the hospital, an irritated staff member may use similar tactics—a fact which does not add to the child's comfort. Sometimes threats are disguised as aggressive jokes which the adult excuses by saying, "It was all meant in fun." The child, however, takes such statements very seriously. Jackson has reported a case of this sort in which a nurse told a four year old boy just before he was to be anesthetized that she was going to exchange her eyes for his while he was asleep. Small wonder that the victim awoke in terror!

Another source of external anxiety for the hospitalized child consists in his exposure—directly or through conversation—to other children who are severely ill or

dying. He applies such distorted knowledge as he gains to his own case. Equally pernicious is the bedside discussion conducted about the child and within his hearing (but without his participation) in a language full of strange words and references to stranger diagnostic techniques. This hoary rite, which is still practiced almost universally, may arouse great fear in the patient about what is wrong with him or what is going to be done to him. One six year old girl with pyelitis heard that there were "bugs" in her urine. She elaborated this information into a fearful fantasy of pregnancy on the basis of her previous knowledge that babies grew from little bug-like objects inside of girls.

Since a known danger is easier to face than an unknown one, fear of injury can be minimized by letting every child, even a two year old, know in advance exactly what is going to happen to him. Such precautions are particularly important if surgery is contemplated. Each child should go to the operating room with full knowledge of everything he will consciously experience before and after the operation. He should know what the room and the people in it will look like, how the anesthetic will be administered and how it will smell. He should know about post-operative pain, where the scar will be, what the purpose of the operation is, and how it will feel to have his stitches removed.

Adequate preparation for splenectomy was particularly important in the treatment of a three year old boy who was nearly exsanguinated many times by violent nose bleeds. In response to repeated traumatic hemorrhages, hospitalizations, transfusions and painful nasal packs, his personality slowly regressed and he developed a state of the most intense anxiety. He began to wet and soil, he no longer fed himself and he never smiled. Speech decreased to monosyllables and physical activity to almost zero. In the playroom he would stand stock still, occasionally stroking a block or a toy. He spent hours crying in bed and he reacted with acute panic to the sight of a white coat or to the slightest attention directed toward his head.

At this point, a woman psychiatrist began to see him three times a week. To establish a relationship of trust and confidence, she gave the patient cookies, fed him, dressed him, read to him and held him on her lap. As he became more comfortable, she encouraged him to play and to do simple things for himself, such as eating and wiping his hands. Occasionally she carefully wiped the blood off his face. This maneuver was designed to help the boy give up his neurotic anxiety about his nose as he learned the difference between painful and benign attention. The child's fear decreased, he began to talk and his play became rather boisterous.

A year after treatment began, a decision was made to remove his spleen. The child was told three weeks in advance, first by the surgeon and then by the psychiatrist. Her explanation ran about as follows: doctors dressed in white suits, caps and masks would take him to a big room called the operating room where they would put him to sleep with something that smelled strong. While he was asleep and unable to feel pain, they would cut open his stomach and fix a thing inside called the spleen, which was causing his nosebleeds. He would ride to the operating room on a cart accompanied by the psychiatrist and would wake up back in his own room with his mother. His stomach would hurt for a while and there would be a big bandage on it. He would have to stay in bed for a few days and then he would go home. (No mention was made of the removal of the spleen as children are very disturbed at the thought of losing a part of the body.) At every subsequent interview, the child was quizzed on his memory for this material. At first he indicated his apprehension by forgetting most of it and by changing the subject to the more pleasant one of cookies. His memory lapses were blamed on his fear and the facts were repeated. He became freer in his discussion and expressed dislike of the operation, which was accepted as natural. Most comforting for him appeared to be the assurance that both his mother and the psychiatrist would be with him. He asked to have his father also and wanted to be sure that he would be able to run around again. Soon he expressed interest in seeing the operating room and each treatment hour thereafter included a pilgrimage there following the exact route which he would travel in reality. On these trips, he held the psychiatrist's hand a little tighter than usual but gave no other evidence of anxiety. His behavior on the ward, also, did not change. He played "transfusion" twice, giving the blood to a baby doll (his little brother or himself?), but he showed no wish to play "operation."

On the fatal day, his mother brought him a new toy. He smiled as he left her and chatted cheerfully during his trip on the cart. Once inside the operating room, however, he did not speak or move, even when the mask was put in place. After three or four deep breaths, he relaxed completely. When he awoke, he complained loudly of pain in the leg where he had been transfused. (It is interesting that this was the only part of his experience for which he was not prepared.) Although he did not recall the purpose and the nature of the operation for some time, his anxiety did not seem notably increased, as was evidenced by the healthy hostility he expressed at having to stay in bed; he wanted to break all the windows in his room.

Six days afterwards, he was back in the office playing "transfusion" and "riding to the operating room." He used a man doll as the patient, applying to it a bandage that resembled his own. He carried his revenge still further by tearing a soldier made of clay into little pieces. A few interviews later, it became evident that some deeper anxieties had been activated by this experience. The boy wanted to visit the operating room again and revealed the fantasy that he was to undergo a second operation. He expressed vague fear that "something else" had been done while he was on the table and became quite preoccupied with broken toys. After some time, however, this theme disappeared from his play and eventually he made a complete recovery physically and psychologically.

Had this child been given less factual information, he would have repressed his knowledge of the coming operation and the real event would have overwhelmed him. The frequency of fears of death after general anesthesia, and of acute anxiety states after tonsillectomy, testifies to the potentially catastrophic effect on children of even minor operative procedures. Although the therapist in this instance was a psychiatrist, what she gave the child was essentially simple: genuine interest, emotional contact and the truth about his future. Since the first two were the vehicle for transmitting the third, it follows that the most important measure for minimizing anxiety in the hospitalized child consists in giving him time with some sympathetic, familiar adult to whom he can express his fears and from whom he can get realistic reassurance

about them. If the child is young, the adult should be a woman, to take the place of the comforting mother. She can be the nurse on the floor, a student, a woman physician, or a motherly attendant. The more fantastic the fears, the more easily can they be dealt with. A boy who was hospitalized for study of his enuresis thought that his arm was going to be amputated, as was learned much later. If this child could have been helped to express his unrealistic anxiety, he could have been told truthfully that the event he feared was not going to happen. In giving such reassurances, one should always mention that others have similar fears, so that the child does not feel lowered by his confession in his own esteem or in the esteem of the person with whom he is talking. During the war our soldiers were told repeatedly that fear was a normal reaction to battle. This simple truth helped many of them through their front-line experiences without bad consequences. They could concentrate on fighting the enemy instead of their consciences.

If irrational fears are easy to deal with, what about rational ones? For example, what of the child who is terrified of a prick in the finger and who has a disease which requires daily blood counts? He cannot be told that he will not be stuck. He must rather be faced with the unpleasant truth—this will be more reassuring in the end than a pleasant lie—and be given a simple explanation of the need for the test. Parents not infrequently conceal coming unpleasant experiences from a child in the mistaken belief that they thereby spare both the child and themselves. The opposite is the case. The child finds himself suddenly faced with a dangerous situation for which he has made no psychological preparations and his vulnerability is doubled by loss of confidence in his protectors. If they have lied to him once, how can he trust them again? In spite of the most careful preparation,

however, many fearful children cannot cooperate for venipuncture. In such cases, the needle should be omitted if possible. If it is essential, then the patient must be helped through the experience quickly and firmly, using restraint if necessary. A short example may illuminate this common problem.

One day I was talking to a child on the ward. In the next bed lay a six-year old girl with rheumatic fever. Two very sympathetic medical students were trying to take blood from her without traumatizing her. They explained very carefully what they were going to do, why they had to do it, and that it would hurt. The little girl bravely held out her arm but, just as the needle came up to the vein, she involuntarily jerked back and started to cry. The students repeated their explanation, again the girl held out her arm, but again her fear was stronger than her self-control. The same scene was played out several times, with everyone in the situation, including myself, getting tenser and tenser. The child knew what she had to do but couldn't quite make herself do it. The oftener she withdrew, the bigger the needle looked and the more scared she became; while the students felt more and more uneasy as their careful techniques failed to produce results. Finally I could stand my anxiety no longer, so I turned around and said to the child, "I know you are too scared to keep your arm still; so I will help you by holding you good and tight." "Why don't they take blood out of the big ones instead of the little ones?" was her reply. (She had an older sister.) I did as I had said. The blood was taken at the price of some weeping and the students left. I talked to the patient a while longer. First I put my arm around her and comforted her. Then I said, "I imagine I made you pretty mad, and that's all right; you can tell me just what you think of me and that will make you feel better." I gave her this permission in an attempt to drain off the pathogenic emotions I thought I had created. Anger can cause anxiety, guilt and fear of retaliation if too much is dammed up inside the personality. I was disappointed when the little girl denied hostility to me and I thought that my psychotherapy had failed. I felt better, however, when she replied to my "Good bye" with "Thank you." Then I realized that she was grateful because I had supplied a strength which she wanted, but could not give herself.

Two principles are illustrated by this short case. Essential painful procedures should be carried out quickly, to minimize fantasy and sense of failure. Also, no harm

is done by restraining a child if restraint is really necessary, if the restrainer is not angry and if he gives the child permission to express hostile feelings afterwards.

Two sources of anxiety have been discussed so far; a third is the conscience. Fear of conscience is often related to excessive criticism or strictness in the home. Particularly potent are threats in which hospitalization has been represented as a punishment for misdeeds. Children say, with surprising frequency, that they are sick because they have been bad. This feeling may have several origins. Added to guilt about real misdemeanors or forbidden thoughts may be guilt for the expense caused by the illness. Moreover, a child usually feels angry with his parents for putting him in the hospital, but if the disease is his own fault, then his hostility is unjustified and therefore bad. Excessive self-blame is often manifested clinically as depression. This symptom is easy to overlook on the ward because a depressed child does not create trouble. He sits by himself, says little, and typically accepts painful treatment without protest because unconsciously he wants to be punished. He betrays his internal discomfort, however, by gloominess, poor appetite, and occasionally, by threats of suicide which are seldom carried out. Children with ulcerative colitis, for example, whose internal problems revolve around their aggressions, are always depressed in the hospital. Doctors and nurses should be on the watch for this symptom because it can be helped by proper treatment. Attention and sympathetic understanding, again, are the main therapeutic tools. In addition, a depressed child should be encouraged to give verbal expression to his angry thoughts because they are a prime source of guilt. If adults do not react critically to such utterances, the child's conscience becomes more tolerant and his depression gradually lifts.

Some children deal with their guilt feelings by the use of "provocative behavior." This is simply a goat-getting maneuver directed at adults with the unconscious objective of being punished. The externally inflicted suffering relieves the pangs of conscience. Such techniques are learned in homes where parents react violently to criticism, spite, or temper. The child tries to apply them in other situations where he feels guilty. Paradoxically, therefore, a guilty conscience may be the cause of bad behavior in the hospital. Obviously punishment solves nothing in such cases. Either it confirms the child's irrational feeling that he can control adults or else it gives him indirect permission to do something forbidden because he knows that he always can get internal absolution by another bit of provocative behavior. Dealing with such reactions on a symptomatic level requires the adult to control his irritation, so that he does not react in the way the patient expects. Calm and firm restriction may also be helpful. If the child's behavior is very disturbing, the advice of a child psychiatrist should be sought.

Anxiety has been discussed so far in terms of excessively strong noxious stimuli coming from the environment or the conscience. It may be caused also by circumstances that weaken the ego's capacity to deal with normal problems of adaptation. Separation from parents is the most important of these factors. As mentioned before, a child is not an independent entity, either physically or psychologically. He needs the bond of a parental relationship to cope with the forces within him and outside of him. Hospital residence deprives him of this emotional support except on visiting days. The situation might be disastrous, were it not for the fact that children can displace their dependent needs fairly readily from parents to other adults. Time and contact are essential

for this process to occur. Only through attention to and interest in, the individual child, can nurse, doctor or attendant be accepted as reliable parental substitutes. Other factors that tend to impair the individual's integrative capacity are physical weakness and pain. The combatting of pain uses up psychological energy; debility lowers the total quantity. In either case, less is available to the organism for its normal functions.

The degree of the child's emotional maturity prior to illness is an index of his ego strength and of value in predicting his hospital adjustment. A boy who has been helped to do things for himself in accordance with his age and ability is able to meet new situations more adequately than one who has been infantilized or another who has been pushed into pseudo-adulthood.

Consideration must be given now to the effect on the personality of long-continued fear and to the defensive measures which the ego may adopt against it. The most frequent pure-culture result of chronic, extreme anxiety in children is regression, which is a slipping back in emotional development to more primitive modes of adaptation and behavior. This phenomenon can be explained in the following way: the more energy one has to use in dealing with acute, apparently life-threatening difficulties, the less is available for mature (but currently useless) skills, particularly those acquired recently. For example, young children may lose sphincter control in the hospital or they may be unable to dress, bathe and feed themselves as they could at home. The dependence and the demands of the individual increase, while his ability to tolerate frustration diminishes. A baby can stand much less frustration than a ten-year-old, and a ten-year-old much less than an adult; and, since the normal reaction to frustration is anger, as the regressing individual becomes more temperish and irritable he is progressively

less able to control this hostility. The clinical picture is well known to every nurse and doctor. It is portrayed in full blown form in the case of the boy whose spleen was removed.

While anxiety usually initiates the regressive process, passive gratification may serve as a motive for its continuance, especially in the emotionally immature. The importance of this factor is seen in compensation neuroses and in those adult or child patients whose treatment includes a liberal amount of bed rest. An individual in bed is less independent than one on his feet because he cannot do as many things for himself. His condition requires that he be waited on. Everyone, at every age, has some secret longing to escape from the responsibilities of the present into the less demanding existence of earlier years. Bed rest tempts the individual to yield to this backward-looking trend because it legitimizes his dependence on other people. The longer the rest, the stronger the temptation. A second factor encouraging regression is the restriction of social contact which usually accompanies sickness. When a person's interests cannot be directed outward toward other people, they turn inward toward himself, and the importance of his thoughts, feelings, wants and discomforts is thereby magnified. Hence, the fewer the visitors, the greater the impulse to regress.

Proper management of regression involves first, reduction of anxiety, and second, gradual re-education to the pre-morbid level of maturity. Both these measures were used in the case of the little boy. It is wise for the therapist to give in to the regressive demands temporarily, because gratification at the level where the patient wants it increases his security and attaches him to the gratifier. The relationship thus established then can be used to encourage either adult or child to regain his independence

by easy stages. Regression can be minimized in pediatric hospitals by providing things for the patients to do that are interesting and that involve as much activity as their physical status permits. In my own hospital one can go on any of the floors and see innumerable miniature attendants pushing dressing carts, helping the nurse with her work, carrying trays, and getting toys for the bed-fast patients. The children get a tremendous kick out of such duties, a kick which involves responsibility as well as fun. Where the situation is not overwhelming, full-scale regression is usually prevented by the development of defenses, which partially neutralize the anxiety. One of the commonest is self-comforting behavior. This may take a great many forms; thumb-sucking, head banging and masturbation are the commonest. Children who have not sucked their thumbs or masturbated for years may resume these habits in the hospital, particularly if they anticipate surgery or are ill for a long time.

A little boy was hospitalized for a week at the age of eight months because his family was moving and there was no other place to leave him. This child had experienced a great deal of physical discomfort early in infancy as a result of a feeding difficulty, vomiting and colic. To ease his pain and to comfort him, his mother rocked him to sleep every night of his life. The care he received in the hospital was hygienic but not very sympathetic, and the child did not see either of his parents for eight days. When he returned home, it was noted that he banged his head rhythmically against the side of his crib whenever he was awake. This habit grew more severe, until the house resounded with the noise. When seen at the age of two, his symptom differed from the head banging which is so common among children in institutions; it was more like a head-rocking. He would bend forward, touch his head softly to the sheet and then sit up. This activity occurred whenever he was alone in his crib; it was stopped only by sleep or by attention from an adult. If the latter refused a request, however, this gentle rocking changed to an angry pounding. The motivation of this peculiar behavior is not hard to understand. The boy simply could not do without a comfort which he had been accustomed to feel as essential for his personal stability. In the hospital he missed acutely

both his mother and her ministrations. No one gave him an adequate substitute gratification, so he took over the job himself. Various difficulties in the family combined to perpetuate the symptom after it had arisen in response to this acute need.

A defense which looks totally different, but which may have the same underlying meaning as self-comforting behavior, is defiance of rules. All instances of defiance certainly do not have the same motivation; in one striking case, however, this symptom was the main device for alleviating anxiety.

A twelve year old boy with poliomyelitis involving all four extremities was a particularly great trial to the orthopedists. With his arms and legs tied in splints, he was expected to lie quietly until his damaged nerves regenerated. To his physician's despair, however, he was in constant motion. He wiggled and twisted until he worked his way out of any and every kind of bandage. Study of his history disclosed that he had been a very rejected child. His mother died when he was young and his father placed him in an orphanage, while the preferred older brother remained at home. The patient returned to live with his father at a time when the latter had just taken a mistress. Out of grim necessity, this child repressed his very strong need for love and became a tough kid who fought his own battles because there was no one who would fight them for him. His illness was very frightening because it threatened him with the loss of this technique for maintaining security. His anxiety increased to panic during one night which he spent in the room next to the respirator, knowing that his physicians expected to put him in it. As he listened to the constant clank of the machine, indeed he felt close to death. After death was no longer imminent, the fear of paralysis still remained. In defying rules, this boy was proving to himself that his body was sufficiently intact so that he could go on as he had before, getting comfort from his ability to beat a hostile world. Each movement was proof to him that some day he would run and fight again. Even after he was taken on for treatment, he continued to be over-active and defiant until he got back his physical integrity. Incidentally, in spite of his wiggling, he recovered completely from his disease.

Some children develop entirely different techniques of anticipating harm, for example, by meeting it with a bluff. I remember one boy who came in for his first in-

terview with me whipped out a pocket knife and opened it up. This boy was not usually very aggressive. He was really quite passive and meek, so I asked him what he was doing. He said, "I'm going to cut the doctors before they can cut me." By this explanation he revealed that he was trying to intimidate a dangerous, threatening adversary. In the hospital some aggressive behavior of children and adults is based on the same mechanism. It represents an attempt to outbluff a fantasied attacker. It will usually give way quickly before exact knowledge of what is going to happen because the truth is generally less terrible than the patient's fantasies.

Neurotic symptoms like those just enumerated can be handled properly only if one has some understanding of their meaning. They should be evaluated in terms of this knowledge rather than in moral terms of good and bad. Since they are constructed because they are needed as defenses against anxiety, one should not attack symptoms themselves unless they interfere with the rights of others. Forceable suppression only exposes the anxiety behind them, thus putting the patient in a worse position than he occupied before. Anxiety, regression, depression, masturbation, thumb sucking, and defiance are all danger signals showing that the child needs help. They are indications for giving extra attention, substitute gratifications, reassurance, and both permission and opportunity to verbalize fears. Restriction may be indicated in occasional cases, but criticism is never in order because it only increases anxiety. Where the meaning of the behavior is obscure, or where it does not respond to appropriate treatment, the advice of a child psychiatrist should be sought.

It is only recently that pediatricians and psychiatrists have recognized fully the psychological implications of physical disease. With the detailed discussion of the

previous pages as a background, this knowledge can be presented in summarized form. Not only does sickness lower the capacity to withstand tension, but it may stir up anxiety from every possible source. When the parents of a sick child become frightened, the latter will in turn, become afraid—often of death or worse. Painful treatment makes him expect further injury while, if he did or thought something naughty just before he became ill, he may interpret his condition as a punishment and then be afraid of both his conscience and his impulses. What got him into trouble once, he thinks, may get him into trouble again. The amount of regression during any given illness will be directly proportional to anxiety, pain, the duration of bed rest and isolation and the amount of enjoyable attention received. It will be inversely proportional to the degree of emotional maturity attained before sickness set in. Hospitalization may increase both anxiety and regression, particularly in children. Separation from parents makes the child feel helpless and therefore hostile to those who put him in a situation where he is vulnerable. These aggressive feelings may be directed at their real objects or at parental substitutes—the hospital staff. They may be acted out openly by abuse or temper tantrums. Aggression may be expressed also in more subtle forms, such as loss of appetite or depression; this is most likely if the child feels guilty about it. Potentially disturbing elements within the hospital itself are: the painful treatments, mysterious hygienic precautions, peculiar clothes, restriction of activity and a different diet. The defenses which the child uses against anxiety consist of regression proper and of neurotic symptoms. Occasionally, when these are not sufficient, a frank psychotic episode of short duration may occur. The following case illustrates the effect of some of these factors on the personality of one child.

The patient, a six and one half year old girl, was seen in consultation at another hospital by my assistant, a woman. She had refused all nourishment except water since her admission twelve days previously and her disturbed behavior led the staff to think that she was psychotic. She cried continuously, conversed with her mother when the latter was not present and expressed the conviction that she was going to die. She had become so difficult to manage that she was put into a private room. Prior to her current illness, the patient's behavior had not been unusual. She had been in bed at home for the past six months following a diagnosis of rheumatic fever by her family physician. During this period her mother, who appeared to love her very much, spent a great deal of time with her playing cards and other games.

It should be mentioned that visiting regulations in this particular hospital were unusually strict. Parents were allowed to come but once a month and could talk with their children only through panels of glass so thick as to be almost soundproof. Real communication across the barrier was possible only for accomplished lip readers.

On psychiatric examination, the child answered questions readily and made good emotional contact. The following excerpts from the interview clearly portray her emotional state. "This hospital is awful because nobody ever comes to play with me. If you can sit and talk with me, why can't the nurses? No matter what anybody says, I won't ever eat again while I'm in here. The food doesn't taste good and if I eat, I will have to take my pills. Those pills make me vomit. I think the nurses are trying to make me sick with them just like they do with all the kids. The other girls liked me at first, but now they hate me. My parents don't like me either. That's why they sent me to this place where I am not happy. They don't even come to visit. I am afraid my mother is tired of taking care of me and won't want me ever to come home again." At this point, the patient trembled and began to cry silently. After the psychiatrist picked her up and cuddled her, she quieted down and continued to talk. She admitted that she liked to pretend she was at home playing games with her mother but she knew this was day-dreaming. Then she said in a sing-song tone: "I will never go home. I will be here the rest of my life."

The girl was told that children often felt deserted by their parents when they were sent to the hospital and that this made them very mad. She denied all hostility to her mother and father but went on to express a great deal more toward the nurses and toward her older brother for not playing with her. When asked if she felt it was wrong for

her to eat (because the examiner suspected that her refusal of food was based partly on a self-punishing mechanism), she simply said that the psychiatrist knew everything, like Superman, but she would not elaborate. At this point, the nurse brought in a cup of water and patient drank it. Then she asked to return to bed, saying that eating and drinking made her stronger so she could sit up. She expressed interest in going back to school so that she wouldn't be dumb, but otherwise, she seemed to look forward more to a resumption of bed rest at home than to an active life. She stated that she could be helped only by prompt discharge. She was told that this might be possible because the medical staff could find no evidence of organic disease.

This little girl's hunger strike is easy to understand. Prolonged bed rest, combined with the cutting off of social contacts at school and with increased attention from the mother, made the child increasingly dependent on the latter for all her gratification. She was placed in the psychological position of a younger child just as everyone is when he is sick in bed. Her character underwent a regression, as was to be expected. Hospitalization and the cruelly aseptic visiting procedures deprived her suddenly of her chief source of satisfaction at a time when she needed it most as a protection against expected physical pain. A black cloud of rage at her mother must have welled up in the child at this point but she could not release this powerful emotion against its real object, because she was afraid of complete abandonment. If she were hostile to her mother (so she thought) then, as punishment, she might be left in the hospital for the rest of her life. To avoid this danger, she displaced her anger onto people who meant less to her and who seemed to deserve it, namely, the nurses and her brother. Refusal to eat was her chief weapon. This symptom probably also embodied self-imposed suffering, as her remark about Superman suggests. Behavior which the staff interpreted as psychotic was merely the acting-out of self-comforting daydreams.

The simplest remedy in this case was immediate discharge home. Fortunately, the recommendation could be carried out. Had a long hospital stay been necessary, more frequent and intimate visits by the parents would have been indicated (to overcome the fear of desertion), as well as increased attention from hospital personnel at the infantile level to which the patient had regressed. Her response to the psychiatrist's cuddling shows how well she would have responded to such an approach. When a secure dependent relationship had been established by such means, the patient could have been encouraged to take small steps toward independence. Indeed, she made such a move her-

self, in asking to return to bed from the psychiatrist's cuddling arms. When her need for her mother had been transferred safely to the staff, the child's symptoms would have disappeared.

Attempts to reduce anxiety should be undertaken long before the patient enters the hospital. The first step consists in explaining his trouble to him. This can be done even with a youngster, if simple language is used. Every person feels better if he knows the nature of his illness, its cause, its location, its ultimate effects and the treatment procedures which will be necessary to cure it. Such information converts unknown dangers into known ones. (Of course, the truth should not be carried so far as to tell a child that he is going to die, even if this is the case.) If hospital care is a likely possibility, this fact should be mentioned early, to give the patient time to accommodate to it. Hospitalization should never be carried out by trickery, as happens all too often.

An asthmatic little girl started out one day to visit the zoo with her parents. She wound up at the hospital, although she was not having an attack. Her parents had lied because they did not want her to make a fuss. One can only imagine her consternation and her sudden loss of confidence in her father and mother when she learned the truth. As soon as she saw her pediatrician, she started to wail, "My mother said she was taking me to the zoo—not to the hospital." The doctor replied, "Your mother always tells the truth and she was quite right. You don't have to stay today, but I want you to come back tomorrow and then you will have to live here for a while." The parents were angry but they deserved the rebuke.

The details of admitting procedure can help or harm a child's adjustment to the hospital. The same physician who saw him in the outpatient department should continue to care for him on the ward, where this is at all possible. His first encounter with the staff of the floor is of crucial importance because it foreshadows the tone of all later contacts. An atmosphere of friendliness, patience and understanding lessens his anxiety and initial distrust. The transfer of dependence from family to staff

is facilitated if the parent can accompany the child up to the floor and both can meet the charge nurse together. The separation which follows is less traumatic if favorite toys can be taken along to share the dangers of the new world. Toys are symbols of a familiar situation and remind the patient that he has a home to go back to. Gifts and mail have the same effect. Time must be provided for reading letters to those who cannot do this for themselves. Relatives should be allowed to visit frequently unless they are anxious. This practice is hard on the nurses and on hospital routine, but it is good for the patients. The generally disturbed behavior seen in every children's ward on visiting day does not do harm, as is commonly supposed; it is rather a sign that the patients have been stimulated by the sight of their parents to work off some of their feelings about being "put away." This is a healthy reaction. Psychic disease is caused only by inexpressible emotions and thoughts; bringing them into the light of day takes away their toxic qualities.

The nursing and occupational therapy staff can do much to help the emotional state of the child. Activities of his own choosing not only keep up his interest in real life and make his stay pleasant, but they also help to combat the regressive tendencies that are mobilized by illness. Schooling in the hospital serves the same purpose and also keeps pupils from falling behind in their class work, which usually increases their anxiety. For those children who must lie still for medical reasons or who are immobilized by anxiety, passive gratifications must be provided, such as radio, television, being read to, cookies, pop and movies. Despite some alarmists' opinions to the contrary, comic books are very valuable, not only as a source of passive pleasure, but even more because they are a channel through which aggression may be expressed in a harmless way. Wild radio programs provide a sim-

ilar outlet. The more physically active a child can be and the more he can socialize with his ward-mates, the less he needs to cling regressively to nurses and the doctors. This is an argument for reducing quarantine regulations in pediatric hospitals to a minimum. Routine isolation of every new admission for the first twenty-four hours undoubtedly does more harm than good.

It may be well to emphasize again that the hospital personnel represent real parental surrogates to the child. As such, he looks to them for attention, interest, affection and guidance. He also may displace on to them negative feelings which he has toward his parents. If he is hostile to his mother, for example, he may be nasty to the nurse. If the latter realizes that this emotion is not directed primarily at her, she will not react personally and will handle the situation objectively. Psychiatrists have to evoke such transferred feelings constantly in therapy in order to make patients aware of their conflicts.

To conclude: Children are small human beings who often feel afraid and helpless. Basically they want to please adults. If hospital staffs can learn to understand behavior instead of judging it, children will be spared much mental suffering which they experience now. Then pediatrician and nurse will be shouldering their full obligations as practitioners of the healing arts.

DR. WEINFELD: Any of you who have had any professional dealings with adolescents or for that matter personal dealing with them, can readily understand why so few psychiatrists have made this age period their special field of study.

We are very fortunate to have as our speaker on the subject of adolescence one who has given a great deal of thought, one who had a lot experience, a tremendous amount of understanding and has made an enormous contribution to the whole field of the problem of adoles-

cence. I present to you Dr. Maxwell Gitelson formerly Director of Clinics of the Institute for Juvenile Research, and currently attending Psychiatrist at Michael Reese Hospital.

PERSONALITY DEVELOPMENT IN ADOLESCENCE

MAXWELL GITELSON, M.D.

Mr. Chairman and Members of the Institute: In order to discuss my topic, it will be necessary for me to review the outstanding characteristics of infancy, childhood and the so-called latency period. Adolescence, after all, does not begin as adolescence. It has its roots in the past history of the individual, and besides this there are certain parallelisms in the phenomena of adolescence to the phenomena of the early life period.

As you have no doubt gathered by this time, the outstanding characteristics of the infancy period (the period prior to the taking of food in an active way, the period of dependence on the breast and the bottle, before cup and spoon feeding have begun) are first, the utter dependency of the individual and second, the utter uncontrolledness of the individual.

Everything is given vent to. Everything is expressed without restraint, without control in terms of the impulses and needs of the individual as a simple animal organism. On the other hand the dependency is obvious in connection with the actual helplessness of that organism.

Now, the fact is that the impulsive tendencies survive and the things which characterize the maturation of the person is that these tendencies, which are in infancy uncontrolled and explicitly expressed, come under gradual and more or less complete control of higher structures in the personality. But they are never fully under con-

trol. This is what accounts for the fact that there has been and is a continuous struggle in all of us between what we are as organisms and what we are as human beings.

The same applies to the matter of dependency or passivity. There is no person who is utterly and completely independent though all of us, more or less, are looking out for our own ends and with our own means ultimately. Nevertheless, if we look around us, in every friendship there is a degree of dependency of one person on the other and in every marriage there is that. In every group situation we find some gratifications of this need for dependency which was at one time 100 per cent.

During early childhood from weaning up until approximately the fifth or sixth year, we see the gradual development of the powers of the individual himself and the gradual retirement into the background of the complete dependency of the infant. Likewise, during that period we see a gradual acquisition of the powers of self-control, a growing increase in the capacity to manage the originally unstinted impulses. This comes about on the basis of what the child learns from its environment and from the influence particularly of its parents. Later on there is the added influence of teachers and of society at large.

What we see during this period is the gradual development of what is colloquially known as conscience and the gradual growth of self-control based on conscience together with the gradual development of individual powers of adjustment and getting along so that the individual is no longer as dependent as he was prior to the existence of these powers.

Then comes the so-called latency period which roughly is the period of life from the fifth or sixth year until puberty. This period is normally characterized by

even more complete socialization of the person. In addition to the factor of conscience which begins to see its development in early childhood, we begin to see the development of the social attitudes, since the individual now begins to be a member (on a small scale) of society in school and on the streets. We now begin to see the individual governed more by the criteria of the demands on him of society at large in terms of what it expects of him. During this period we see also the further maturation and refinement of the individual powers, talents and capacities of the person. In short, during the latency period, when development is normal, we see emerging a small edition of the character and personality of the future adult.

On the other hand, in disturbed children, whose development is going on unevenly or with distortions, difficulties in interpersonal relationships and in social adjustments first become manifest during this period. It is in the latency period that we begin, for example, to see in the most extreme instances, early schizophrenias or delinquency. This is so because in the latency period we have the first complete though tentative crystallization of the personality around the things that enter into the formation of personality; namely, the impulses and characteristics with which we are born, the talents which we develop, the controls which we learn, and the social criteria which we acquire.

Now, at puberty we come into a completely new phase of development and yet as I have mentioned there are certain parallelisms to the previous development of the person.

In the first place, and without further elaboration, I would say that the more uneventful the prior development of the personality has been, the less eventful will be the adolescent period. However, there is no adolescence

which is without eventfulness. It is a question of quantity rather than quality because there are certain constants that characterize adolescence.

One constant which is probably familiar to all of you from common experience and general observation is that there are certain dramatic things that obviously happen to the person at puberty. There are physical changes which are undeniable. They are measurable. We can measure changes in the bony structure. We can measure characteristic changes in the skin. We can observe, in terms of effects, the changes in the size and function of glands of internal secretions. In the center of all of this we see the emergence of sexuality in terms of the beginnings of what it will ultimately be in mature, so-called adult, men and women.

Now, the changes of a physical nature which I have described are attended by changes in the emotional nature of the individual. You will have observed yourself that a relatively nicely behaved child of age 7, 8, 9, 10 or 11 will suddenly become a restless, irritable child; or, a child who has been out-going and active, will become a moody, preoccupied child. There will be changes not only in structure and function physically speaking but there will be changes in what the person seems to be to himself and what he looks like to us. There will be mood changes and emotional changes. These changes in mood reflect physiological changes and changes in the external powers and abilities of the developing person. Just as there have been phases in the earliest development of the child which were characterized by bursts of growth and maturation, just as when a nursing infant becomes another sort of an organism after it has been weaned, has learned to manipulate objects, has learned to crawl and to use its first words, so with the adolescent and the

changes which occur in him. These are changes which have to do with new integrations and new functions.

There are internal reactions to these developments. For example, in early childhood we see the child developing pride of accomplishment. One day it hasn't been able to walk and the next day somehow or other it staggers to its feet and manages the distance from one chair to another or from mother to father and you see a consequent development in the attitude of the child towards itself which may be verbalized by the statement of self-esteem. "I can do it. I am somebody." Similar reactions occur to all such positive accomplishments in childhood and throughout life. On the other hand failures in natural development may produce a decrease of self-esteem. This may be particularly the case at puberty. The reason for this is that many of the things that happen in the course of the natural development of the organism are not understood by the person to whom they are happening. Normal lags in development may be looked upon as defects or failures. Furthermore, to the extent to which developments are normal and understood, they may be nevertheless connected with social taboos, which make them appear to the boy or girl as defective or bad things. Thus many of the attitudes of inferiority which we see occurring at puberty and during adolescence have to do with the fact that the individual begins to feel stirrings in himself which may be inacceptable or may impress him as dangerous, particularly the sexual stirrings.

The individual, emerging from later phases of childhood dependency, is moving into a phase of life in which he expects of himself a greater degree of independence. It is taken for granted that he will have certain powers, capacities and abilities. Because the individual has not yet left behind him his childhood and has not quite at-

tained his adulthood, we see here a transitional period in which he finds himself full of self-doubts. He has the outlook and the hopes and expectations of the adult while at the same time he has the persistent memories and feelings of the child. He has the stirrings of various impulses including the sexual impulses and he has the feeling that there is something about him which he does not know how to deal with. In addition to feeling helpless, he also feels guilty. As a result he feels inferior and inadequate and loses self-esteem and self-confidence.

I have been going ahead of my story a bit. The fact is that the physiological developments that introduce the cycle of events which I have been discussing have a certain rhythm in our culture and in our climate. The fact is that these developments tend to occur earlier in the female than they do in the male. There is an earlier gonadal maturation in the female than there is in the male. The discrepancy may be as much as a year or two so that by the time you are seeing a group of boys and girls of the same age in their early teens, you are seeing quite a different phenomenon than when you are seeing a group of boys and girls of ages 8, 9 or 10. The latter are substantially the same kind of people. They aren't fully differentiated sexually during that age period. This is a period of relative tomboyishness for many girls and it may be a period of sissiness for some boys. In any case even without such extremes to refer to, there isn't a great deal of difference on the surface between boys and girls prior to puberty. But with the pubertal development we see a differentiation which for a time makes the girl of fourteen quite superior and quite a bit older in her development than a boy of fourteen. This has to do, as I have said, with the differences in the rate of internal developments and with the consequent differences of rate in the psychological developments that parallel these in-

ternal physical developments. Whether it is a boy or girl, the dynamically important thing which introduces the changes is the upsurge of internal impulses of various kinds. For example, a very neat child may become a sloppy child. The child of 8, 9 or 10 years of age who has learned to comb his hair and keep his hands more or less clean and to make some kind of a decent appearance at school becomes careless about appearances. He loses his so-called good habits.

In addition to the upsurge of the instincts and the return of primitive tendencies we see, at the same time, changes in what we call the defenses. We will see either a weakening or tightening of the defenses. I have described some defenses but I should pause to say what a defense is. The word "defense" is a cliché which we psychiatrists use to describe the capacity of human beings to erect barriers against the uncontrolled or unmodified expression of their animal natures. I have indicated that during early childhood there is a gradual development of the personality such that there is a gradual coming under control of those things which characterize us as animal organisms in contrast to the human being as a complete human being.

Now, with the upsurge of new emotional tendencies and impulses at puberty and during early adolescence, things happen to these defenses. We have either a weakening or a tightening of the defenses. There may be, for example, an early period of so-called weakening of the defenses in which the individual for a time goes to pieces and we see all sorts of things that are troublesome. The individual himself is not very happy with the things that are happening. Then there may follow a phase of a so-called tightening of the defenses when the individaul leans over backward and becomes overcontrolled. These phases may alternate or there may be mixtures of the two.

You will see one kind in the morning, another kind when he comes back from school and a third kind when he goes to sleep at night and has nightmares.

One might describe adolescence as having the quality of iridescence. There is a play of color as you see it on a pool of water with oil floating on it and this has to do not only with the angle from which you happen to see the child, but it has to do with the angle from which the child may see himself at that particular time. It has to do with the balance of forces in himself as between the defenses and the impulses; various things may determine which will be stronger at any given moment.

Thus a boy who is just beginning to feel the gonadal stirrings may be perfectly all right until something happens externally which gives a further stimulus to the hormones that are circulating within him. For example, he may go somewhere where there is a crowd of girls dressed up in pretty dresses and behaving like girls. This becomes a burden to him because he does not know exactly what is happening to him, or what he is supposed to do; or what he is supposed not to do; or supposed to feel or not feel. In such an instance we may see the boy converted into a restless, or moody, or over-rigid and overcontrolled, or utterly uncontrolled person, depending on many factors that sum themselves up in him in that particular situation.

By and large, the normal trend during adolescence is towards the development of some kind of a final orientation towards the self, towards society and towards the things that characterize one's relations with one's fellows, eventuating in what one finally is as an adult. If we compare early childhood and the adolescence period of life, we might say that during the first we see the testing of the capacity to master physical reality while during

adolescence we see the testing of the capacity for the mastery of social and interpersonal reality.

Now, what does that mean? It means that if you see a child of one year of age you see that it is trying to hold a glass skillfully. You see that it is trying to use its fingers precisely. You see that it is trying to evolve some complete notion of itself by feeling its toes, or feeling its belly, or feeling its ear or feeling somebody else's fingers or nose. It is continuously exploring and testing its physical environment and trying to establish its capacity to manage it. If in contrast we look at an adolescent of age fourteen, we see quite a different thing and yet it is the same basic thing; namely, an impulse to mastery. We see the adolescent constantly trying to manage himself in relation to other adolescents, in relation to father, to mother, brothers and sisters, employers, teachers; always trying out some new way, failing, trying out something else, and finally, by and large arriving at some relatively stable notion as to how he must go about living with himself and with other people. This is the difference between the mastery of physical reality and the mastery of the social interpersonal reality.

The essential forces in the adolescent period are of two kinds. They are propulsive and retropulsive. The propulsive tendencies are biologically grounded in the tendencies of organisms to grow and mature. The retropulsive tendencies are the consequence of the preadolescent history. They have to do with inclinations to remain undeveloped, immature, dependent, and uncontrolled. Again we can look to our common experience. We can look at any adolescent and we will see variations between clinging to mother, and drawing away from mother. The adolescent may on the one hand cling to parental permission, advice, or approval. On the other hand, there will be the boldest self-assertion, the boldest attitudes:

"I can do this." "You can't tell me." "I can stay out until midnight." "I know all about it." "I can drive the car." Etc.

There is in the same individual the push to become adult and mature and the pull-back to remain where he was. The reason for that, as I have stated, is that on the one hand there are the biological tendencies to mature, to become adults, to become mothers and fathers, to assume responsibilities and so on; while on the other hand, there is the tendency to have things done for us arising from our history of dependence. The latter tendency is particularly strong in our culture which tends to be overprotective of its children. The habit of having things done for us is often very strong. Add to this anxieties arising out of not knowing just how to go about doing new things for one's self and there is a consequent mixture of fear and self-indulgence which may interfere strongly with maturational tendencies. To summarize, the things which hold back the individual are the habits and comforts of dependency, the fears of the instinctual developments and the fear of life and independent responsibility. These act as drags on what is a normal tendency: namely, to mature, to grow up and become mothers and fathers and participating responsible, active members of society.

Passing now from the essential forces at work to the adaptive goals of adolescence, we may summarize the latter as follows: emancipation from the father as mentor, from the mother as protectoress, and from the parent of the opposite sex as the central object of affection.

Looking around, you know how much there is a tendency for fathers and daughters and sons and mothers to pair off. We cannot go into the details of what enters into that, but there is a tendency for the mother to become the central object of affec-

tion for the boy and the father to become the central object of affection for the girl. If that remains the case, then there may develop the phenomena of spinsterhood, or bachelorhood. There is nothing wrong with that excepting that they don't quite fit with other things which are necessary to and characteristic of our particular culture and society. In the ordinary course of emotional and social development, there is in our culture a trend towards the emancipation from the mother or the father as the central object of affection.

There is the tendency, particularly on the part of the son, towards emancipation from the father as the mentor, as the person who knows "how" and says "how" things are or should be. The normal adaptive goal is the development of the capacity for independent self-assertion.

Finally and very importantly, as an aspect of these other developments, there is the achievement of heterosexuality, that is the attainment of the capacity to love a person of the opposite sex with the ultimate wish for parenthood.

To the extent to which these goals are achieved, we have the normal maturation of an adult personality out of adolescence. To the extent to which there are deviations, distortions or failures, we have the various kinds of pathological developments which it is not our concern to discuss today.

The social dilemma of the adolescent is that he is no longer a child and not yet an adult. He is pulled between these two states of being.

In general there are the following methods of reaction to the problems of puberty and adolescence. You will observe the evidences of that as you look around you in ordinary life too. First there is the adolescent who makes a violent attack on his problems. He plunges into

everything. Nothing fazes him. Good or bad, he is going to try it. He apparently seems to be without fear and without anxiety and yet what he is largely manifesting is what the psychiatrists refer to as a counter phobic attitude. This is the kind of attitude we manifest on a bright November morning when we go down to the lake and instead of putting just our toes in the water we plunge in head first and overcome our fear of the cold shock at once. Second is the other extreme, the adolescent who collapses or retreats before the anxiety of growing up. That is the adolescent who manifests shyness, moodiness, retreating attitudes, isolation and so on.

Generally, however, there are the various in-betweens; the compromise formations of various kinds. For example, girls, instead of daring to manifest their development as females in respect to boys may find some kind of a solution which goes through the motions of keeping them oriented as women and yet doesn't expose them to the dangers of womanhood. Thus there are girls who are good fellows, who are always going around with a crowd of boys, who are very popular at dances, whom the boys like. They seem to like the boys. Everything is swell. They have a nice social life. But the strange thing is that they seldom will permit themselves to be alone with a boy. They seldom will permit themselves to have a single relationship with a single boy. This type of compromise may be a transient phase in either a boy or girl. They go through the motions of a development without fully letting themselves in for the development. They test the temperature of the water befor going into it, so to speak. And it may apply to development other than those of sexuality.

One of the subjective developments in adolescence is a flowering of interest in one's own body.

In the male this interest has to do with his strength and power, with pride in strength and power. It has to do with the particular role of the male in our culture. It has something to do with biological differences, but we are not so very sure about that because there are after all species in which the female is the strong arm of the pair. But in our culture, the tendency is for the body pride in the male to be concerned with potency and with the wish for power and ability in whatever may be the social role which he falls heir to.

On the contrary, the body interests of the female have to do with the problem of loveliness, as you well know. They have to do with loveableness because, by and large the role of the female in our culture is not to go out and find someone to love, but to find someone to be loved by. It's a much more "sitting and waiting" kind of matter. There are all sorts of angles involved. There are men who wait for someone to come and love them and women who go out and get their man, so to speak. But the underlying differentiation between the man and woman in our culture is that the man develops in himself the interests and capacities that have to do with being the actor, the one who does the loving and the earning; whereas the woman tries to make herself loveable and wishes to be loved, protected and supported by a competent man.

In connection with all this there is among adolescents, a normal tendency towards sexual curiosity. This curiosity about the opposite sex is often covert and shielded by shyness. But nevertheless, it is there. Despite this curiosity which manifests itself covertly during early adolescence there is a period of sexual segregation in which boys and girls for a time don't have very much to do with each other because of their anxieties. Later on however, a gradual reapproachment takes place

as developments occur which makes sexuality less dangerous and more possible of achievement.

In the end the male becomes more consciously aware of the problem of his status. He becomes more consciously aware of and concerned with questions about where he "stacks up" and where he is going to wind up in contrast to and comparison with other men. This, of course, has to do very much with the choice of a career. It has very much to do with the establishment of prestige at school and in one's relationships on the streets and in the clubs. You can see how this must be the case since adolescence is a period of trial of the boy's future place in the world. The competitions which are characteristic of the adolescent period in our culture are more definitely interpersonal than earlier in life. If you will look at a group of boys who are playing together at the age of six or seven, and if you will look at a group of adolescent boys on the street corner, you will see this kind of a difference between the two age groups. The younger boys will do something and will shout: "I could do it; I did it," meaning "I have verified my power to do something." If you listen to the older boys on the street corner, what will you hear? You will hear: "I can do it better than you," or "I beat you," or "I came out first." The emphasis now is on comparison.

Now, there is not a pure culture of these different attitudes in these different age periods. The latter is characteristic, however, of the competitiveness and interpersonal self-assertion which appears in adolescence and is determined by the character of our culture. The former is more a biological manifestation of the need of the individual to be assured of his capacities and power to perform and to survive.

It is in early adolescence that the gang emerges among boys and the gang is a very interesting thing. It

is not necessarily a bad thing. But it can become a very vicious thing. Adolescents have to flock together. They have to flock together to support each other.

Recent studies by educators particularly at the University of California and at the University of Chicago have demonstrated the existence of what is known as adolescent peer groups. As you may gather from that designation they are referring to the fact that adolescents tend to flock together in order to find some sense of equality. As individuals they are neither children nor are they adults and as individuals they are in a very anomalous position. They have no equality to anything. They cannot demand what the younger sister gets from mother. They cannot do what the older brother or daughter does in the business or in school and so on. They flock together to eke out their personal deficiencies, for the sake of mutually increasing their strength. They flock together in order to jointly dare and to jointly try out things which as individuals they might be too anxious to do. They flock together to learn from each other and the fact is that adolescents learn more from the next older age group of adolescents in this period of life than they learn from their parents. That constitutes one of the problems which we have in dealing with adolescents.

It might be much more difficult for an older person to manage an adolescent group than it would be for a slightly older person. It might be more difficult for the head of a nursing school to deal with the problems of her students, than it would be for an instructress who has only finished her training a year or so before. The gap in the first instance is too great.

The problems of adolescents separate them and isolate them from adults and particularly from their parents and parent surrogates and bring them closer to those who are more like themselves; in other words, the ones

who are in the same boat as themselves. We have to consider that generally in managing adolescents in school, in training situations, and in social relationships.

So there is among males normal delinquency, normal sowing of the wild oats, normal ganging together, normal adventurism and wanderlust. These things by themselves are not pathological. They become pathological in certain instances. They are not pathological in themselves but in the terms of context in which they appear.

I shall now briefly pass over the emergency defenses of adolescence.

One of the most common of these is a hyperdevelopment of intellectuality. About this time in life we all of us become more or less philosophical. The philosopher sitting on his mountain top is really quite far from the dangers and troubles and vicissitudes of life down in the valley where there is plowing to be done. We all of us become at times intellectual and philosophical. We try to figure our way out of the mess we find ourselves in. This is more characteristic of certain adolescents than others. But in general this tendency to ponder, to try to make sense out of things is perfectly typical of the adolescent.

There is also ascetism. Call it idealism. A characteristic flowering of adolescence is ascetic idealism. This is when we have our transient Communist phase or transient over-religious phase, which may, in many instances, pass over altogether but, in some instances, becomes the motive for a career and, in still other instances, may remain as normal residues in the religious or political attitudes of the adult person. During the adolescent period this hyper-religiosity, this hyperasceticism and excessive idealism may bring some persons up against bitter disillusionment by the facts of life which actually surround them. Normally these are transient emergency

defenses against the upsurge of instinctual tendencies which are unacceptable, which have not yet been returned to their proper place in the scheme of things, not yet been managed by the individual and integrated by the individual so that they can take their proportionate place in the whole symphony of his life.

There are in the male transient sexual manifestations which are typically those which we refer to as masturbation. This is a necessary emergency defense of the male adolescent period. It is a defense which is dangerous to tamper with because it serves to protect many individuals against instances of severe neurotic or psychotic breakdown. As such it must be lived through and tolerated just as snobbish intellectualism must be lived through, just as idealism which is often priggish has to be lived through and allowed to take its course.

Inferiority feelings and depression are very common in adolescence and the reasons are obvious. The inferiority feelings have to do with the sense of incomplete capacity as measured by the adolescent's own high standards of achievement. Gradual increase in ability and powers of achievement tend to correct this. The depressions have to do with guilt feelings which have to do with those impulses which threaten to be uncontrollable such as sexual feelings and hostile competitive feelings.

Returning to the female, the psychological situation is one of mutual scrutiny and rivalry. The rivalry is concerned with the question of who shall be loved. It takes the form of: "Who is prettiest? Who has the nicest ribbon or nicest dress?" But the real issue is, "who shall be loved?"

There is a covert scrutiny and appraisal of those who are to do the loving, the male. There is in the midst of all of this the tendency to subdue and squelch the aggressive male who is too threatening. If you have listened

around on the street corners or in the clubs, you will have seen evidences of how girls put a boy in his place because he may be overbold; or it may be because the girl is actually overtimid. On the other hand, there is the tendency on the part of the girl to stimulate and to entice the less aggressive male. Thus while the girl's anxiety makes it necessary that she control, if the boy is too timid or too disinterested, she is in danger of losing an opportunity to attain her full development as a woman. There is the danger that she may never find any one to love her if she does not do something about it. There is therefore a general orientation towards a final compromise solution in which there will be love without danger. Girls will therefore normally tend to stimulate the overtimid boy and to squelch the overbold. There may be girls who never get away from their defensiveness against the male and against sexuality. There may be girls who never overcome their fears. But by and large there is the tendency to arrive at a middleground solution which makes living and loving and family life ultimately possible.

There are particular problems of the adolescent girl which have to do with the particular characteristics of her sexuality. I am referring to the menstrual cycle and to the menarche which ushers in adult femininity. There are a great many anxieties connected with that for the simple reason that there is a great deal of obscurity in terms of simple facts and knowledge as to what the meaning of menstruation is. There are a great many anxieties connected with the onset of menstruation which have to do with the girl's feeling about herself with regards to being a woman at all. One might say that in the normal situation, in the absence of physical pathology, that the onset of menses and the menstrual cycle should be a totally uneventful thing taken in stride by the maturing woman. Where we see difficulties, where we see anxie-

ties, we have to look into the question, first of all, of simple ignorance as to what the thing is all about. Secondly, and probably a great deal more prevalently than we like to admit, there may be problems in the deepest emotional layers of the person that have to do with the total attitude and total orientation of the person towards her status as woman.

There may be deep-seated anxieties which cannot be dealt with by any other than technical psychiatric means. There may be less complicated things. But wherever we see disturbances which are more or less lasting with respect to the menses, we must look for trouble. However, we should not be too prone to make a pathological diagnosis of the early reactions to the menstrual cycle because these may in the course of maturation disappear. They may be absorbed. They may be integrated. Knowledge may come. Emotional changes may come during the course of adolescence which will put the thing in its proper place.

In general we must not be too hasty about making a diagnosis of pathology during adolescence. One of the great difficulties in diagnosis during adolescence is that so much which is transient and normal and which the individual is capable of managing and integrating ultimately by himself looks on the surface very much like that which becomes neurotic and even psychotic in some individuals.

On the basis of what I have already said, you can see that there are a number of problems that are perfectly characteristic of the nursing student who is in the main an adolescent.

Adolescence, by the way, does not end with the teens. Adolescence has a more or less definite onset although there are earlier onsets and later onsets particularly in our culture. Nevertheless, adolescence has no

limited span which is definable. Many of the problems of people in their twenties are problems of adolescence. Many therapies go astray with individuals in their twenties because they are taken at their face value as adults, in terms of chronological age, rather than being recognized as adolescents. So I think by and large you must look upon your nursing students as adolescents. By and large they are adolescents when they come to you and they may still be adolescents when they leave you.

It may be that during the teen years which have been spent at home and going to high school your nursing students have been able to advance and retreat in their emotional development. They have been able to progress in the direction of their adult development and when they became afraid, they have been able to make some kind of regressive return to the home and to the bosom of mother or protection of father or whatnot. But now they go into nursing training and they are really on their own. They are on their own regardless of whether they have completed their development in the direction of capacity for being on their own. So there is a double problem for them and a double problem for you who deal with them.

There is the problem of recognizing the fact of their residual dependency. There is the problem of recognizing their residual impulsiveness which needs the supplementary controls (I say "supplementary controls" not harsh disciplines) of those who are presumably adult.

There is at the same time this same person who is well on the way to adulthood and who cannot be treated fully as a child but whose self-respect and self-esteem requires that she be treated with respect and esteem as we would an equal.

It is a very delicate problem to give these youngsters the security of dependence and the security of control

which is not so obvious that it offends their self-esteem as near-adults. This is a very important point and constitutes the whole problem of dealing with youth in college or girls in training.

You cannot overlook the fact that they need your support and control. But you also cannot overlook the fact that you have to make it palatable. You have to give it to them in a way which does not injure their pride and self-esteem as near-adults. They need security but they cannot be made to feel inferior by being hampered or being overprotected or overcontrolled and the chances are that if you offend their pride too much in respect to the things of which I have been speaking, that you will stimulate rebellions and self-assertions which will exceed what they would spontaneously have manifested had their pride and their self-esteem not been violated.

There is another aspect of leaving home which has to do with all this. After all, at home these kids have been somebody's darling in the family and at home they might have been quite big fish in a small pond. Well, the unfortunate thing about going into the world is that successively we have the situation of big fish from small ponds coming together in bigger ponds and they can't all continue to be the big fish. This has to do, of course with the self-assertive strivings, and the competitiveness which blossom during adolescence.

It takes a great deal of art to help an older adolescent girl with all of her normal self-centeredness to find a place for herself which is reasonable, which is gratifying, which doesn't violate her self-esteem as the little big fish, and yet doesn't give her any delusions about the fact she is living in a real world, with many others like herself. These problems require sensitiveness and consideration in the supervising personnel. They require real maturity on the part of the persons dealing with these girls.

It must be clear that the trainees will manifest a great deal of anxiety and that they will cope with their anxiety in various ways. Some of them will tremble and be pale and they will show manifest fear which nobody will fail to recognize. They are just plain scared to death of the world into which they are adventuring. Others of them will react to anxiety by techniques of denial. They will over-react in the direction of appearing not to care, of seeming to be unafraid, and they will blunder and stumble into many things because of that. You have to realize very often that what you see is not a rambunctious girl, not a conceited girl, not a rebellious girl, but an anxious girl who is somehow trying to cope with her anxiety by denial of it in her feelings and in her activity. And you have to remember that they are anxious because they overevaluate the dangers and the problems of being adults. They may think of everybody else around them as being paragons of virtue or skill or knowledge, and they may fawn on the persons whom they think of as paragons because they feel so weak and helpless and inadequate themselves. They will not do that without resentment and without bitterness and without putting themselves in the danger of exploding with envy and jealousy of those who they think are superior to them. So again you have the problem of bringing them to some real recognition of the fact that there are no paragons, that there are no gods except in heaven, that there are no miracle makers and no magicians and that all of us have troubles, all of us are human beings, and that all of us have capacities for surviving and dealing with life in some way. That takes modesty and the capacity for respecting the other person on the part of the supervising staff.

In terms of what I have said you will see how much there is to this matter of educating young people, whether

it's in nursing or anything else. It is a problem which requires the fusion of techniques of protection and techniques of control with techniques for stimulating and encouraging actual maturation. With regard to the latter I think the most important thing is the example of those who are the leaders and the instructors. For what the adolescent girl needs more than anything else is the assurance that somebody else whom she respects has lived through what she is living through and has come out all right in the end.

Adolescents cannot receive that assurance from their parents because there is too broad a gap between them. There are too many issues between themselves and their parents. Nor can they receive that assurance from those who are surrogates for their parents because surrogates might just as well be the parents themselves. By this I mean that we carry a screen between us and the other person and we tend to see the other person in terms of the persons whom we have known previously. We react to the other person in terms of the persons who have been significant to us previously. Thus the adolescent may have the same trouble with parent-like adults as with the parents themselves. But the adolescent can receive the encouragement and the impetus to live well from those young adults who quite obviously have managed successfully the difficult task which they themselves are up against now. It is these young adults, the instructors "young" in age or in spirit who can encourage in the most vital sense, by their living example, the normal maturation of the adolescents who are their students.

DR. WEINFELD: There isn't very much—in fact, there is nothing that should be added to Dr. Gitelson's comments and anything I could say would take the edge off of all of the pearls that he dropped and all of the wisdom that he imparted to us this morning.

He did it in his own inimitable way. I knew he would. He covered a vast amount of material which I know will be helpful to you in understanding your own problems, problems of your students and in dealing with problems of your students.

(The movie "The Feeling of Hostility" was shown at this time.)

MR. DE BOER: The meeting is adjourned.

FRIDAY AFTERNOON SESSION

November 5, 1949

DISCUSSION GROUPS

Recorder for Group 3:

The discussion was opened regarding the two movies, one on rejection and one on hostility. The individuals depicted in the movie were projected into the role of the nurse; what type of nursing student would she be; what type of pediatric nurse would she make.

As in the case of Claire in the movie, how can we give help to students who have problems but who do not seek help or realize that they need help?

Suggestions made, in schools of nursing, students have well formed patterns of behavior, hence our problem is not one of prevention, but of recognition and in helping to solve them. Many problems are the result of broken homes, which we talked about at length here.

The suggestion was made that an interview with each student by a psychiatrist or psychiatric consultant as the means of detecting any possible difficulties of the student would be the very best thing. Some schools have already put that into practice and it is working out very nicely. It is something to think about in the future for other schools.

Is too much emphasis being placed on looking for problems, and would not a positive approach help elimiate many problems?

What should determine the level of maturity of students? Is chronological age a good determinant? Are students more mature at 17, or so on? How do we know? We don't. We will need to establish criteria for deter-

mining whether a student is mature enough or not to enter schools of nursing. How do we develop better personal relationships with students and graduates?

1. That listening is often of more value to a student than giving helpful advice.

2. That it is necessary to develop a more really understanding attitude.

3. Encourage the student's willingness to talk it over with somebody.

4. Instructors often discourage students by condemning first and listening later. Listen first and then follow the indicated method of procedure.

5. Allow student to anaylze her own mistakes. She will benefit more from this than to have the instructor or supervisor tell her she is wrong. Then let her draw up her own solution which she would perhaps follow.

Another, try to give students more consideration as far as home visits are concerned. This is especially true to the beginning students. Certainly parents should be allowed to visit children hospitalized a little more often than is now true, and we can try this with the beginning student nurse. Better interpersonal relationship between the staff nurse and the student nurse could be fostered. This would also foster better integration between nursing service and education by giving more attention to the general duty staff nurse. Especially immediately after graduation. The student is pampered and things are planned until graduation, and then as a graduate she sinks into the group of nondescript workers just there and that is all,—just a general duty nurse. There should be more concentrated counselling for the senior student to prepare her for the sudden transformation from student to graduate. Encourage the senior students' independence; prepare them for the responsibility they are about to assume for the first time.

Then observe the nursing education program as well as the economic organization of hospitals, which foster the exact thing we are trying to remove, that students and graduates are encouraged to be much more dependent then we want them to be. They are encouraged to remain under the same protective guidance of the school or hospital. They live in the Nurses' Home under the protecting wing of the hospital. Living conditions for the graduates foster shop talk on off duty hours, poor attitudes toward their work, great fatiguability which tends to make them asocial. They participate in few social activities outside the hospital. These are things we hope to discourage. The techniques for fostering independence in the classroom, ward situation and in living quarters as well are problems which we may well spend more time discussing and focus more attention on in the future.

Another recommendation is that the transition from senior student to graduate be rendered much less abrupt than now.

Are instructors in schools of nursing actually prepared for teaching? This was considered in relation to mental hygiene concept of teaching. Many instructors find themselves teaching courses they were not prepared for. Is she prepared for teaching manual skills? Is preparation for examination enough? Is she prepared to give counsel which the students will need? Often she is handicapped because she has preconceived prejudiced ideas toward the student. She feels insecure because she is not prepared as well as she might be, is reluctant to say she doesn't know everything, and so places herself above the reach of the students.

These recommendations were made: That the instructors' personal lives and privileges be considered (often she is called upon to serve or give counsel on off duty time when she should feel free to participate in ac-

tivities she might choose), that more consideration be given her so she in turn might feel closer to the student in giving counsel when they need it, the emphasis to be placed, first and foremost on her willingness to be perfectly frank and friendly, and have a very open approach to the student so she may feel free to come to her for guidance and counsel as the need would arise.

Recorder for Group 1:

We started out discussing the students' adolescence, which often lasts far beyond the regular period into her senior year and after graduation. Then the second question discussed was, does the child get enough attention when it is taken from home and brought to the hospital? Are we thoughtful enough of it? Do we treat it as the mother does, because when they are taken away from home where they have comforts and sometimes haven't been told what to expect in the hospital, we should not make this experience more traumatic, but explain to them and be a mother figure to them. Giving improper care to children will cause anxiety and apprehension. When a child goes for an E.E.G., we can tell it what is going to be done in a simple way, not going into it too far, which might frighten the child, but in some cases the doctors didn't approve of the nurse giving explanations because the student doesn't know how much to tell the child and goes into it too much in detail.

One of the doctors said O. T. was very important with the patient, a helpful adjunct to the hospital, especially in pediatrics.

In psychiatric nursing, the same as in pediatrics, we should remember that we shouldn't take up all of the time doing the necessary work, but take time out and say a kindly word to the children.

In connection with the student, we spoke of counselling, how best to take care of this situation. We spoke of the Big Sister idea, or class advisers. Different schools use different methods of counselling. We also spoke of a reconstruction of the curriculum. One school said their professional adjustments and public health were really the same. And so they were thinking if it were acceptable, it would be a good idea to combine the two subjects. In charting, pertinent material is important, but supervisory material takes a lot of time and could be carried out as well in using the check idea of daily baths instead of recording it.

Another very important thing discussed, the student as well as the patients need affection and security to make their lives complete. You can have one and not the other and you are not happy. You need both.

We also discussed how to make our students return to our home school. Maybe by the administration of the hospital and the school itself having a closer affinity, and not being so much at loose ends, might help to bring students back. As long as not all schools have affiliations in psychiatry, one mentioned a part time psychiatric nurse at the hospital to instruct students, as being of help.

Recorder for Group 4:

Most points have been covered, but Miss Bigler was especially anxious that we talk about patients and applications of some of these principles to their care. It is important for us to understand their fears and moods and the demands they make as part of their general feeling of insecurity. In connection with the thought brought out about fear of the unknown being more harmful than is known, we feel that is important in connection with the student nurses. We can do a great deal about helping

them before they meet some difficult situations in the hospitals, and that they are situations every nurse does meet, thereby reducing some of her fear.

It was also suggested that the students' council of the school might be one of the groups which might help. They might help in the orientation of the younger student because it is the younger person who often can be the most help. It would also give her a chance to express some of her hostility which she might be afraid to express with older people.

In considering the problem of rejection in the movie, we wondered what the effect of dismissal has on the student nurse, and what can be done about that. Counselling at the time of dismissal would be important, but fundamentally it would be better to screen students out before personality problems might develop. We did discuss the reasons for the fact that there is 32% mortality in student nurses because of theoretical failure in their work. Dr. Brown, in her new book, stated: "We expect far too much of them in academic achievement."

Recorder for Group 2:

Our group began with a consideration of the film and the main character. We then wondered what we would do in counselling and working with the student nurse presenting the same problems. We considered also the kind of student nurse we want and what we will develop in her, not only on an intellectual level, but with an appreciation of the basic principles of nursing and knowing how to apply them. In helping the student to understand behavior, we felt that she should have a concept of the normal child and adult and where could this be introduced in the curriculum. Psychology in the preclinical period was discussed, and by helping the student in her own adjustment, where she could apply what she

would learn. The nursing school has not changed to meet the needs of present society. We do have to face the reality situation of service needs in the hospital, and it is very difficult for the student nurse who has a heavy service load, to consider the total personality of the patient when under the pressure of service. Many thought students were not given much opportunity to apply what they are learning even about personality because of pressure.

We then wondered about the auxiliary worker, and decided that the auxiliary worker needs recognition and assurance and orientation herself on the service she is on.

We felt that nursing education should be patient centered as well as educationally centered. Not just the intellectual nurse, but the nurse who understands nursing care, nursing as an art. It is also important for the hospital staff and administration group to have a fine concept of mental health too. We felt a great need for maturity on the part of the people working with student nurses. Some of the personal tensions in our own lives are reflected in our work.

A great deal can be taught in considering not only the sick child, but also the normal, well child, and from there on we discussed opportunities in the community for giving the student an understanding of this, such as trips to a nursery school where the well school child is observed and where skilled people work with the child.

Our conclusion might be that with all of this broader aspect of training and education we will help the student nurse to develop a broader sociological background in nursing.

Recorder for Group 6:

We opened our discussion with the consideration of a problem: the idea of the supervisor being a paragon of

all that is perfect, and the problems which would arise. Emotional difficulties might arise by the supervisor misinterpreting the adoration of the student, and it was felt better that the supervisor be sure she is not too perfect, because if the students do adore her, sometime when she does make a mistake, she will tumble from her pedestal. It was also felt that adoration for the supervisor might blind her to the students' faults. It is desirable to have the supervisor more mature than the students so they will go to her. It was thought advisable too that the supervisor should concentrate on the problems of all the students rather than on the problems of one student.

There was also the problem of the student's difficulty with those in authority. When you do have a good relation with students, they will come and criticize those in authority above the supervisor. The supervisor can play an important part there if she has good personal relationship. The students will accept criticism she will make.

We also discussed discipline and tried to define discipline, what it meant, and its relationship to counselling, and it was felt by some that discipline and counselling can't mix. It was also brought out that discipline alone without self-discipline was fruitless. We also felt counselling should develop self-discipline in the student.

We felt the need for a change in the ideals in schools of nursing, and this should be brought out through faculty education.

The question was put: how can you take what you have learned here and put it into practical and constructive use? That perhaps could be done by staff education meetings, through individual discussions, using informal methods, by institutes in schools of nursing, by becoming more familiar with more techniques so better

to handle material given to us in institutes. Also movies would be a good source of material in order to put across information we had received.

Recorder for Group 5:

We talked about the psychological problems of the student nurse, and what tools we have to help in adjustment, etc. Many of the subjects have been covered, such as class organization and committee work with students.

We talked about boy and girl relationships and how to foster and encourage them. One of our main points was lack of money to do a lot of things we felt would be good for students and which they would enjoy.

Then regarding counselling, we wondered if the age of the counsellor was so important; the qualities and special differences of individuals as regards each counsellor; some respond better to a male, some to a female.

Then we listed all the different activities most of the schools have. We talked about discipline and regulations also, mostly on the idea of how much freedom we should give the student. Eighteen year olds were not able to go out on their own with no supervision at all. We need to give protection and guidance, but we should relinquish them gradually so that by the time they are seniors, the jump from student to graduate would be gradual and they would be self-confident and able to take care of themselves.

Then we talked about qualities of the graduates, head nurses and supervisors. All agreed she should be a warm person and an example to the student, and an understanding person. We talked about giving encouragement in femininity, and we were enthusiastic about the charm course. It taught the student body mechanics, make-up, clothes sense, etc., which give them all the things we stress in a way in which they are ready, willing

and anxious to accept. Who should teach that course? DR. ROBBINS: You have all accepted the ideas proposed here, and I have been quite happy to see how easily you have accepted them. I got the impression that many of you came with these ideas partially formed, but not completely crystallized.

I want briefly to discuss a few questions. How are you going to take back to the hospital what you have learned here, and apply it in a practical way? Do you feel that the Mental Hygiene Society could more adequately elaborate and apply these concepts by having men give these lectures at the hospitals? Mr. de Boer has suggested that you make recommendations directly to the staff about changes which would be indicated from what you have learned here. How can you do this in a practical way? One way that suggests itself is in the staff meetings. These could be opened to those of you who have attended the Institute, and several sessions could be given over to those problems discussed here. How do you feel about another Institute like this for the supervisory members of the staff?

I had the impression that most of you were convinced of the practicality of what has been discussed here, but that what you hoped for was to receive some confirmation of your ideas. Now with this stamp of approval you can go back feeling secure in your approach to members of your staff.

There will be distributed to you the proceedings of this Institute. How will you use this? One suggestion for the use of this material is that it be used as a basis for discussions in the staff meetings. The material would then be available to the head nurses and supervisors. With the backing of this authoritative source, they may more easily be convinced.

A final point for consideration in long-range planning. Perhaps some day there will be in each hospital a Mental Hygiene Unit, either as a separate department, or as an integral portion of all the hospital departments.

I wish once again to express my appreciation for your interest and active participation in this Institute. I hope that tomorrow's session will lend the finishing touches to an *already successful* Institute on nursing education.

SATURDAY MORNING SESSION

November 6, 1948

The meeting convened at nine-forty o'clock on the first floor of the Student Illini Building, University of Illinois, Dr. Rudolph Novick, presiding.

CHAIRMAN RUDOLPH NOVICK: This is our third and final day of the Institute. There have been several questions that have come up from the members of the group. One was relative to the proceedings. The proceedings will be published in some form or other.

Yesterday and the day before we very superficially touched on the subjects of early childhood and adolescence. Today the theme will be maturity. For our speakers today we have Dr. Alexander who is the Director of the Institute for Psychoanalysis of Chicago and Clinical Professor of Psychiatry, University of Illinois College of Medicine. Following Dr. Alexander we will have Dr. Leon Saul who is from Chicago, but presently at the University of Pennsylvania. He is head of the Department of Psychiatry there.

Dr. Saul was very kind in agreeing to come for this one meeting. After Dr. Saul's paper there will be discussion from the group. Dr. Saul will lead that discussion and then the meeting will be adjourned.

We will now have Dr. Alexander's paper on emotional maturity. Dr. Alexander:

EMOTIONAL MATURITY

FRANZ ALEXANDER, M.D.

The expression, "maturity", refers to a significant phase in the growth of a living organism. Maturity is achieved when individual growth is completed and the

organism is ripe for propagation. The concept of maturity is used also in psychology and psychiatry. In this field it designates that phase of personality development which corresponds to biological and psychological maturation. We call a person psychologically mature after he has reached a certain level of intelligence and emotional outlook. If the development of a person is undisturbed, biological and psychological maturation progress more or less parallel with each other. Usually, however, biological maturation proceeds ahead of emotional maturation.

Each phase of biological development is characterized by certain well-defined psychological attitudes. Biologically, the newborn infant is completely dependent upon the mother and accordingly his emotional attitude is characterized by this dependence. He seeks gratification for his needs from the mother; his security is based on being cared for and loved by the mother. Gradually, the first signs of independence appear. The child learns to use his biological equipment, he learns to focus with his eyes, to masticate food, to coordinate the innervations of his skeletal muscles, he learns how to grab objects and to walk. He learns to exercise conscious control over his excremental functions and to communicate his needs by speech. All these functions at first are mastered separately. The eyes learn how to focus, the hands how to grab, the legs how to walk; but finally all these functions become coordinated with each other and the child is able to spot objects in environment, approach them and take hold of them. The greatest step towards independence is accomplished by the development of the functions of intelligence which allow a high degree of independent orientation in the surrounding world. The most important phase of development begins with the maturation of the sex glands during puberty. By now the growing

organism has acquired all functions, to which finally the faculty of propagation is added. There follows a period called adolescence which in many respects is in sharp contrast with maturity although it introduces maturity. We speak of adolescent attitudes often when we want to emphasize that they are juvenile and immature. We refer to adolescent boastfulness, insecurity, awkwardness, instability, etc. Although biologically the adolescent organism reaches the end of its growth and is in possession of all its potential faculties, psychologically it can be sharply differentiated from maturity. In this age the parallelism between biological and psychological development does not prevail. Biological growth by now is a full phase ahead of psychological maturation.

In order to define maturity, it is helpful to point out in detail the striking differences between adolescent and mature emotional attitudes. The mentality of the adolescent can best be understood if we consider this phasic difference between the faster biological and the slower psychological maturation. Adolescence is as if the biological functions of mature sexuality were foisted upon an organism which emotionally is not fully prepared for it.

The outstanding features of adolescence are insecurity and awkwardness which often makes a comical effect. Here is a young man or woman, biologically full-grown but in many respects emotionally still a child. One has the impression that they do not know what to do with themselves in their newly acquired status. Their insecurity manifests itself in self-consciousness, both about their body and their personality. They do not know what to do with their hands and feet, there is a lack of spontaneity in their movements and speech and a

constant effort to overcome their own feeling of awkwardness. A full-grown body is entrusted to an inexperienced mind.

Another conspicuous feature of adolescence is an excessive competitiveness. The adolescent feels as if he were constantly in a test situation. He must prove to himself that he is already a man or a woman. Noblesse oblige! Bodily they are full grown men and women and this obliges them to behave as full-grown men and women. The only way to do this is by measuring up to others, both adults and contemporaries. Adolescent assertiveness, bragging, intensive competitiveness are the natural manifestation of this state of mind. The inexorable law of growth imposes upon them the obligation to perform according to their age and faculties. Lack of experience, the novelty of this new state, is what creates the feeling of inadequacy which the adolescent tries to overcome by competing with others.

The understanding of adolescence gives us the clue to the essence of the mature state of mind. This consists in overcoming the insecurity and in being able to take one's self for granted. The period of competition during adolescence gives the person opportunity to prove himself to others and to one's own self. Moreover, this steady competition affords a continuous practice of one's full-grown capacities. During the period of adolescence the young person gradually grows emotionally into the advanced mature status which biologically he had already reached several years ago. The self-confident attitude of the mature person is based on taking himself and his capacities for granted. This is in sharp relief to the insecurity of the infant and of the adolescent. As a consequence of this inner security the mature adult's interest no longer centers around the self. It can now be turned outwards towards the environment.

Maturity can be best understood from the so-called vector concept of life. Life can be viewed as a relationship between three vectors: 1) the intake of energy in the form of the nutritive substances and oxygen; 2) their partial retention for use in growth; and 3) the expenditure of energy to maintain existence, its loss in waste, heat and in propagation. As long as the organism grows, intake and retention outweigh expenditure. Propagation may be understood as growth beyond the limits of the individual biological unit and follows the pattern of the propagation in monocellular organisms. The process of growth has a natural limit when the cell reaches maturity. Thereafter reproduction occurs through the division of the cell. When a biological unit reaches a certain size, addition of substance and energy becomes impossible because its capacity to organize living matter has reached its limit. Individual growth then stops and propagation serves as a means of releasing surplus energy.

All energy which is not needed to maintain life can be considered as surplus energy. This is the source of all sexual activity; it is also the source of all productive and creative work. This surplus of energy shows itself in the mature person in generosity, the result of the strength and overflow which the individual can no longer use for further growth and which therefore can be spent productively and creatively. The mature person is no longer primarily a receiver. He receives but he also gives. His giving is not primarily subordinated to his expectation of return. It is giving for its own sake. Giving and producing, as Dr. Leon Saul correctly emphasizes in his book on maturity, are not felt by the mature person as an obligation and duty; he gives, produces and spends his energies with pleasure in the service of aims which lie outside of his own person. Just as for the growing child, receiving love and help are the main sources of pleasure,

for the mature person pleasure consists primarily in spending his energies productively for the sake of other persons and for outside aims. This generous outward directed attitude is what in ethics is called altruism. In the light of this view, altruism, the basis of Christian morality, has a biological foundation; it is a natural, healthy expression of the state of surplus characteristic for maturity.

You may have the impression that I am speaking of something unreal, of a blueprint instead of reality. But we must realize that things in nature never correspond to abstract ideals. The platonic ideal of maturity in its pure and complete form is never found in nature and is only approached by human beings to a greater or lesser degree. Every adult carries in himself certain emotional remnants of childhood. Even the most perfect machine does not fulfill the ideal conditions of Carnot's famous heat machine which exists only on paper—an apparatus which works with the theoretically calculated maximum effectiveness in converting heat into useful mechanical energy. There is always attrition; a part of heat energy is lost for productive uses. The same is true for the living organism, which essentially is a complicated thermodynamic machine.

Whenever life becomes difficult, beyond the indidual's capacity to deal with its pressing problems, there is a tendency to regress towards less mature attitudes, in which a person could still rely on the help of parents and teachers. In our heart, deep down, we all regret being expelled from the garden of Eden by eating from the tree of knowledge—which symbolizes maturity. In critical life situations, most persons become insecure and may seek help even before they have exhausted all their own resources. Many occupations require so much responsibility that a person's ability is taxed beyond his

inner means. I could not use a better example than the occupation of the nurse. The nurse's function towards the patient in many respects resembles the maternal role because it is so one-sided in relation to giving and receiving. Like the child, the patient demands help and attention and gives little in return.

It must be realized that there is a proportion between receiving and giving which has limits for each individual and which cannot be transgressed without ill results. As soon as a person begins to feel that his work becomes a source of displeasure for him, this is the sign that the balance between giving and receiving is disturbed. The load must be reduced to such an extent that the work becomes again a source of pleasure. It is therefore highly important that the occupational and the private life should be in a healthy compensatory relationship to each other. Many occupations in which a person assumes leadership and must take care of the dependent needs of others, involve an unusual amount of responsibility. Even the most mature person has his own dependent needs, requires occasional help and advice from others. In occupations which require a great deal of expenditure of emotional energy there is a danger of what might be called living beyond one's emotional means. Harmonious human relationship in marriage and friendships are most suitable to fill these emotional deficits and restore the balance between emotional receiving and giving. Vacations and recreational activities are of similar significance. And finally one can not overemphasize the importance of nature's own great and universal device for restoring spent energy: sufficient amount of sleep.

This leads us to another important characteristic of emotional maturity, to the faculty of appraising realistically one's own limitations. The mature person is able to face not only the facts in the outside world but also

the facts concerning his own self. He adjusts his work, his ambitions and efforts to these facts and seeks his gratification within the limits set by external conditions and by his own personality. This faculty to adjust one's needs to the existing and continuously changing external and internal conditions we call adaptability. It enables the person to meet in a flexible manner changes in the environment and changes in himself which are involved in the process of growth and decline through aging. This is the function of the central governing portion of the personality, the ego. This flexible adaptive behavior stands in sharp contrast with automatic responses, for example, blind obedience to existing standards. The child's ego is not capable of sizing up each single situation on its own merits. As we say, he has not yet acquired a sufficient amount of discriminatory judgment. Lacking those faculties on which flexible adaptation is based, experience and precise reasoning, the child's behavior is regulated by parental supervision and guidance. He cannot yet use his own mind and must by obeying them borrow from the experience and knowledge of the adults.

Mature behavior, however, is characterized by flexible adaptation to a given situation. The patterns learned in the past do not fit every new emergency. If the world and the individual were both stable, fixed automatic patterns would be sufficient to insure harmonious adaptation to given conditions. Adaptation is much simpler therefore when conditions remain unchanged. The same is true for adults who live under extremely stable conditions. They do not need flexible adaptation to a changing environment. The typical Parisian or Viennese is a fish out of water elsewhere. These fine representatives of their native culture do not even attempt to change their way of life when they emigrate but create little Parises and Viennas abroad. A similar example is the tragedy

of the older generation in a rapidly changing world. Superb representatives of their own age, they become disgruntled and neurotic when a rapid social change forces them to live in a new era.

This problem did not arise during relatively static periods like the feudal period in Europe. As such times conditions and customs remained the same from generation to generation and the place of each individual in society was rigidly determined. The same patterns of behavior descended from parents to children for centuries. Sociologists correctly emphasize rapid social change as the most conspicuous feature of our present industrial era. Not only do two subsequent generations live under different conditions, but an individual during his own lifetime has to readjust himself repeatedly to rapidly changing material and ideological conditions. As a youngster he lived in a world of rugged individualism, in his twenties he was taught the blessings of political paternalism only to face in his mature years a renaissance of individual initiative. From this it is obvious that the first requirement of industrial civilization is a highly flexible and adaptable personality. As we have seen, the instrument of flexible adaptation is the conscious ego. The comfort of living according to well-tested traditions is not enjoyed by man in the modern era. Habitual behavior patterns do not require conscious deliberation but become routine. Men living in a period of rapid change must develop the faculty of rapid adjustment. They must therefore be more aware of themselves and of their needs than was necessary for their predecessors.

We have characterized the mature person as one who is able to use those energies not needed for survival in a productive, creative fashion by expending them for the sake of others. We have seen also that this generous productive state of mind requires

security. Only that person who is not involved in his own internal conflicts, who is not handicapped by anxiety and confusion about his own problems is able to turn his interest outwards. In order to obtain such internal peace of mind, the person must be able to adjust his internal needs in a flexible way to changing external and internal conditions. In order to have surplus energy which can be spent productively, the ego has to accomplish his adaptive functions in a smooth and economical way. Finally, we have seen that the complexities of modern life make the adaptive functions of the ego more and more difficult. The inevitable conclusion is that to reach emotional maturity in this present era became more difficut than it was in those periods in which life was simpler and regulated by well-tested traditions.

In its struggle for self-preservation humanity develops in each period of history the knowledge and skills it needs for survival. One of the crucial problems of our industrial era has been to create sanitary living conditions for people in large cities. An understanding of contagious diseases became a question of life or death, and bacteriology and physical hygiene arose to meet the problem of congested areas. Dynamic psychiatry plays a similar role in respect to the psychological difficulties arising from rapid cultural change. The aim of psychoanalysis is to increase the effectiveness of the conscious ego by replacing automatic adaptations and repressions with conscious control and flexible adjustments to the changing conditions of modern life. It helps a person to approach more closely the ideal of a self-reliant mature state of mind. This requires facing facts not only outside but within ourselves. The Greek maxim, "Know yourself", may once have been a luxury; today it is a necessity. Man can adjust himself to his changing environment only by knowing himself, his desires, impulses, motives and needs.

He must become wiser, more judicious and more self-reliant; in one word, more mature. Otherwise he will become confused and frightened and regress to the ways of dependent childhood and thus become the prey of power-seeking minorities who will induce him to believe that his security lies in doing what he is told.

DISCUSSION OF DR. ALEXANDER'S PAPER ON "EMOTIONAL MATURITY".

LEON J. SAUL, M.D.

The student nurse has all the problems of adolescence plus the problems of being a student nurse. In the first place, she must adjust to the fact of adolescence—to the fact that she has powerful drives, to the fact that she is physically but not emotionally mature, and to the fact that she is actually very inexperienced with her feelings and with life so that she has to adapt to her own psychological and biological development.

Secondly, she must adapt herself to the separation from home, especially if she comes from a distance. This is psychologically true of all girls, however.

Thirdly, she has to adapt to the learning of a profession and training for a career, which involves not only the learning of skills, but also the attitudes which go with the profession of nursing.

Furthermore, she must solve the problem of mating because adolescense and post-adolescence is the period where both sexes look around and go out and date in order to find the person whom they are going to marry.

Finally, she must learn about life, not only skills and careers and personal problems of finding a husband, but also what people are like and what really goes on in life—its pleasant aspects, its politicing, and the whole complicated interplay of feelings between people which con-

tinually builds up, alters and breaks down amongst them.

In order to handle all these problems of adjustment the student nurse must have an insight into psychology and psychodynamics. The latter term originated with Freud who said that to understand the mental and emotional life, one had to have a knowledge of it 1) historically, 2) dynamically, and 3) economically or quantitatively. This means that to understand how an adult behaves, one looks for his history, his childhood pattern—if he behaved that way then, he behaves the same way now. The dynamic means the interplay of forces, so psychodynamic means the interplay of psychological or emotional forces, e.g. a nurse gives out a great deal to the patient all the time so she should have some interest coming in to balance this. Maybe this give-get relationship will be disturbed by various historical factors. Suppose the nurse were spoiled or deprived at home when she was little. That would leave her with a heightened need for love when she grew up, so that if such a girl gives out a great deal to the patient, she needs more replenishment than the next nurse. But whatever the history, psychodynamics means the interplay of emotional forces within the individual and between people—the motivating forces that make them tick. Psychodynamics is a vital part of the curriculum, not only for knowledge of oneself, but for the handling of others and all human relations, and in the case of nurses, with particular emphasis on their handling of patients.

Insight alone is not enough during the difficult stage of being a student nurse—during this stage the girl needs a certain amount of actual emotional support. We might call it "sympathetic understanding." This is where the role of the supervisor comes in. Years ago a nurse I knew said that a good supervisor has to have love in her heart for the student nurses. This has to premeate the

attitude that the nurses will need some actual libido, sympathy and feeling, with their understanding.

There are numerous topics that I might suggest for discussion. The first is the problem that the student nurse faces in her separation from home, the transition from home life to independent life via the nursing school. Secondly, there is the question of the psychology of the nurse in her relationships to all those with whom she is in close contact. We should discuss the nurse's emotional relationship to the supervisors as well as to other nurses, doctors and patients. There are the extra-curricular contacts with young men, because this is, after all, the period when girls are looking for a mate. There are the purely platonic relationships with friends of both sexes. Finally there is the girl's relationship to herself.

Let us consider the last question immediately—the girl's relationship to herself. A nurse should really know the fundamental human motivations, how they apply specifically to adolescence and to nurses. I think a great deal can be taught on the basis of books and through supervisors and trained psychiatrists. A classical psychoanalysis is absolutely impractical, but much could be accomplished in one or two interviews. I have had a little experience with adolescence in consulting with college students, and sometimes there are really dramatic therapeutic effects, just from understanding what the problem is. For example, there was one boy whose parents were missionaries overseas leaving him alone at college. His work fell off, and he couldn't concentrate. We know that the ability of a student to do work is intimately related to his emotional state. This boy continued to feel depressed and uncomfortable, until one day he was having lunch and suddenly found himself walking down the street. He had a very brief absence of consciousness when he got up and walked out. This scared him and he came to me.

That was two years ago. The boy was reacting to the fact that he was all alone, had just come to college as a freshman and had absolutely no roots anywhere with his parents away. He felt that he should be independent and making a go of it, because his family were making sacrifices for him. He didn't know the intensity of his need for dependence and emotional support and he was living beyond his emotional means. His relief with one interview when this was explained to him was tremendous.

The same thing is true with students whose parents have always wanted them to get straight A's. From the time they were little they had to excel at school. When they come to college they meet others whose parents have made the same mistake in their background. Furthermore all the students have high IQ's and the competition is much stiffer. They find their accustomed life technique doesn't work so very well and soon, under the stress of holding their own, they lose all interest in the content of their studies. Their energies are drained from their other social relationships and they get anxious and develop all kinds of symptoms. If you can show these students what they are doing, even though trained in this way for a lifetime, you can often turn their interest to the subject, by showing them that the best way to get good grades is to be interested in what they are doing. It is possible to get a great therapeutic effect in a single hour.

Some students will come with their problems voluntarily. But there are many who won't come and they are often those who need help most. This may be because they have a little too much guilt. They are afraid of what will happen when they see a psychiatrist because he reads their soul and they don't want their soul read. They have problems of over-dependence and they defend themselves about being dependent. They fail to see that the

psychiatrist will help them to be more independent. They think to see him means to regress and be dependent and they feel therefore that they must work their problems out for themselves. Sometimes this whole resistence can be dealt with very quickly and the students can be helped a great deal just by understanding what goes on.

Because of this capacity to understand and the therapeutic response of adolescence, I believe one interview per nurse might be very valuable. They are taught the principles of emotional development, they read books about them—a skilled person can help the students see them in terms of their own makeup. The capacity for understanding is greater in younger people because they have not yet developed chronic ways of handling their troubles.

Let us consider next the relationship of the student nurse to the supervisor. A girl who has just come out of home and into life and all of its problems will look for emotional support and she will look in large part to the supervisors as mothers who will give her understanding and help, libido and emotional support. This may come out in the open with some girls, but certainly many of them defend themselves against it and become quite hostile to the supervisor as a defense against a threat to their independence. They may really want to come and talk over their problems, but they assume a generally hostile attitude to protect their independence.

The supervisor will also get a lot of reactions which the student nurse had to her parents, since the girl has just left home and is beginning to adjust to the separation. I believe you will find that any student nurse who had a good, easy, warm relationship with her parents and did not resent their authority will have the same easy relationship with the supervisor who has taken over some of the responsibility. On the other hand, a girl who

had too restrictive parents or who had a problem in relation to authority, is either going to want to run loose without any kind of restriction or else will be rebellious against all regulations. The way to meet this problem is to understand as much as we can of the supervisor's psychology as well as that of the student nurse.

If the student nurses get this training, the supervisors should get it and more. Certainly counselling service is needed. Nursing supervisors are already grounded in the medical tradition, but they would need very specialized training. The counselling should be under the supervision of a psychiatrist and should not be based on some technique or method, but on rational knowledge and understanding.

More and more, people now realize that understanding of what is going on is an important and necessary thing in adaptation. Thoreau said that "the mass of men lead lives of quiet desperation." You could modify that and say "men and women" and you could modify the "quiet" and say "not so quiet." Everybody has a great many problems and everybody finds life difficult. If they think they can get something that is going to help, they want to get it. And now they know that psychiatry has something to offer and they turn to it whenever they can. If they can go to a psychiatrist, they go to him; if they can go to a counsellor, they go to him. It is inevitable that many abuses result. The demand for expert psychiatric knowledge far exceeds the supply.

The nurse's relationship to the patient is equally important to her adjustment. Many students wonder what they have to give to someone who is old enough to be their grandfather, even if they know the principles and have the words formulated in their minds. The patients themselves look upon the students as being so young and immature. How can the gap be bridged? The one way

to handle it is to understand it. Knowledge is power. If the patient says the nurse is immature, that is not always the case. What Peter says about Paul, often tells more about Peter. His criticism is apt to reflect something within himself, specific or general. Dr. Alexander discussed the specific psychology of various psychosomatic conditions, but there is also a general psychology of the *patient* which is, namely, the kind of reaction that people have when they go to the hospital. For example, you know better than I whether there is any truth in the saying that doctors are the worst patients. They have to maintain their position and still be the doctor. They don't want to let anybody diagnose them or treat them. It is hard for their ego to accept the patient role.

The position of being a patient means different things to different people. I had a girl recently who has a lot of burdens and troubles in life. She went horseback-riding for a little escape from them, and, although they were trotting very, very gently, the horse stumbled and fell on her. At first there was a question of a fractured pelvis and a trip to the hospital to be examined. When this was found unnecessary, she was bitterly disappointed, because she thought she was really going to have a big fuss made over her, and also a justified escape and rest.

There are other people who have the opposite reaction and dread the hospital. They may go there for some minor matter and yet they have all kinds of irrational fears.

I don't know whether the cure lies so much in the nurse as in the patient. But the nurse can be more mature in handling the problem if she has an insight into the general psychology of patients and of nurses, too. *Nurses*

should know as much about psychodynamics and modern psychiatry, as they do about physiology and modern medicine.

Some books which might be of help in understanding what makes people act the way they do are listed below:

Franz Alexander: Medical Value of Psychoanalysis

Cannon: Bodily Changes in Fear, Hunger, Pain and Rage

Sigmund Freud: Introductory Lectures

K. Menninger: Love Against Hate

K. Menninger: The Human Mind

W. Menninger: You and Psychiatry

Leon Saul: Emotional Maturity

DR. NOVICK: (After discussion from the floor)—

Now, to get back to this Institute. I am sorry that Dr. Alexander had to leave. He had a previous appointment, but I am sure I can speak for you when I carry my words of thanks to him for being with us today.

I certainly appreciate Dr. Saul's making a special trip to Chicago just for this express purpose. He is not here for any other reason except to appear at this Institute. I know how busy his schedule is and I want to thank him for coming down.

As for you people, we hope you have gotten a great deal out of this Institute. I know that we have learned something from it.

I want to thank you all.